BioDerm

2026
BENEFITS GUIDE

Plan Year: January 1–December 31, 2026

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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. Please see page 32 for more details.

OUR COMMITMENT

Our goal is to provide a high-quality comprehensive benefits package to our valued associates. That includes working to balance the rising costs of healthcare with the growing needs of our associates in one of our nation's most challenging times.

Our associates are dedicated and committed to providing the best service to our patients, customers, and business partners – in turn we are committed to caring for your future.

Sincerely,

Kevin Goyer
Vice President, People

This benefit resource guide includes the relevant information you will need to make the best decisions for you and your family.

EMPLOYEE CARE CENTER

Discover a New Approach to Healthcare with The Baldwin Group's Employee Care Center!

At The Baldwin Group, we believe that employees are truly the greatest assets of any organization. That's why we have established our Employee Care Center (ECC) designed to help you gain a better understanding of your benefits and help you navigate important healthcare-related matters.

Here's why you should take advantage of the ECC:

- **Expert Healthcare Navigation:** We help you navigate through complex healthcare processes, research provider and prescription options that may lower your costs, and help you learn to use self-help tools.
- **Clinical Support:** We offer healthcare decision and claims support, to help you understand your benefits and aim for first-call resolutions. We also offer dedicated bilingual support in Spanish.
- **Confidentiality:** We prioritize your privacy. All your health information and consultations are handled with utmost confidentiality and are HIPAA compliant.

Join us in this journey of prioritizing health and wellness. Let Baldwin be your partner in health, every step of the way. That's our commitment to you because we care! The ECC is available Monday-Friday, 8 am-5 pm EST. Contact us at 866-784-2242 or via email at mybenefits@baldwin.com. Scan the QR code to add the ECC to your contacts list!

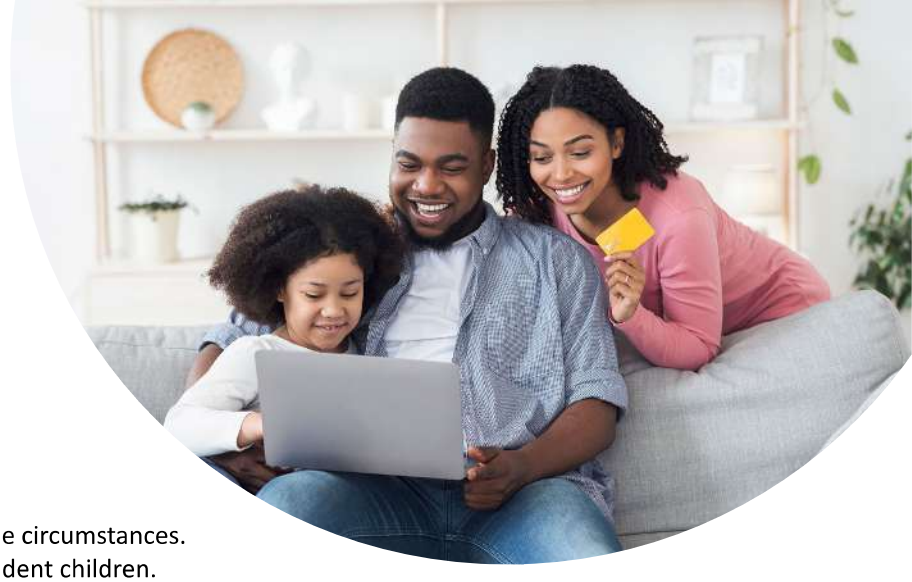
IMPORTANT CONTACTS

COVERAGE & CARRIER	PHONE NUMBER	WEBSITE / EMAIL
Employee Care Center	866-784-2242	mybenefits@baldwin.com
Medical: Cigna Policy Number: 628833	800-244-6224	www.mycigna.com
Telemedicine: Cigna Policy Number: 628833	888-726-3171	www.mycigna.com
HSA: Optum Bank Policy Number: 8X2433	866-234-8913	www.optumbank.com
FSA: WEX	866-451-3399	www.wexinc.com
Dental | Vision: Guardian Policy Number:570512	800-541-7846	www.guardianlife.com
Life and AD&D | Disability: Guardian Policy Number: 570512	800-541-7846	www.guardianlife.com
Accident | Critical Illness | Hospital Indemnity: Guardian Policy Number: 570512	800-541-7846	www.guardianlife.com
EAP: Uprise Health (through Guardian) Policy Number: 570512	800-395-1616	worklife.uprisehealth.com Username: Matters | Password: wlm70101
Legal: LegalShield	866-470-1694	www.legalshield.com
Pet Insurance: Pet Benefit Solutions Policy Number: BIODERMPET	888-913-7387	www.petbenefits.com

Bioderm, Inc (dba Bravida Medical) Contacts:

- Lorraine Kodron – People Manager North (Geneva): 630.345.4252 | lkodron@bravidamedical.com
- Jennifer Actis – People Manager South (Yorkville & Largo): 727-800-1984 | jactis@bravidamedical.com

ELIGIBILITY



ASSOCIATES

Associates with full-time status, who work at least 30 hours a week, are eligible for insurance benefits effective on the first of month following date of hire.

DEPENDENTS

You may also elect coverage for your dependents in some circumstances. Eligible dependents may include your spouse and dependent children.

The term child includes:

- A natural or legally adopted child.
- A foster child, if placed in your home with state statutes prior to their 18th birthday.
- A spouse's child(ren) residing with you and dependent upon you for support; or a child whom you or your spouse have a legal obligation to support, even though not living with you.

COVERAGE	MAX AGE	END DATE
Medical	26	End of the month the dependent reaches the maximum age
Dental	26	End of the month the dependent reaches the maximum age
Vision	26	End of the month the dependent reaches the maximum age
Voluntary Life and AD&D	26	The day the child reaches the maximum age
Worksite Benefits	26	The day the child reaches the maximum age

CHANGING YOUR BENEFITS

SECTION 125 | PRE-TAX BENEFITS

Some of the benefits offered by Bioderm, Inc (dba Bravida Medical) are covered under the IRS Section 125 plan. This plan allows your premium contributions to be taken out of your paycheck before taxes are applied. This results in a greater take home pay for you. Because your share of the cost of the plan is taken from your paycheck on a pre-tax basis, the IRS requires that you only change your elections during Open Enrollment or when you experience a Qualifying Life Event.

EXAMPLES OF QUALIFYING LIFE EVENTS INCLUDE:

Marriage, divorce, legal separation or annulment

Birth, adoption, or death of a child or spouse

Qualified Medical Child Support Order (QMCSO)

Change in your dependent's eligibility status

Loss of coverage from another health plan

Change in your residence or workplace (if your benefit options change)

Loss of coverage through Medicaid or Children's Health Insurance Program (CHIP)

Eligibility for a state's employer plan premium assistance program

If you would like to make a benefit change due to a status change, you must notify People within 30 days of the life event. Otherwise, no changes will be allowed until the next annual Open Enrollment. Remember, if you change your benefit elections, your premium contributions will change.

HEALTHCARE TERMS TO KNOW

Copay

A fixed dollar amount that you pay for certain covered services. Typically, your copay is due up front at the time of service.

Deductible

The amount that you must pay each year for certain covered health services before the insurance plan will begin to pay.

Coinsurance

After you meet your deductible, you may pay a coinsurance, which is your share of the costs of a covered service.

Out-of-Pocket Maximum

Includes copays, deductibles, and coinsurance. Once you meet this amount, the plan will pay 100% of covered services the rest of the year.

ADP ENROLLMENT

Open Enrollment is your opportunity to add, drop, or change your coverage for the upcoming year.

To ensure your benefit enrollment is processed and your coverage is active, all employees are required to enroll during Open Enrollment 2026. If you do not enroll you will not have benefits for the 2026 plan year.

BEFORE YOU BEGIN

Before you logon to elect your benefits, be prepared.

- Read your Benefits Resource Guide. This guide includes details, explanations, and rates for all of the benefits offered to the employees of Bioderm.
- To elect coverage for your spouse or children you will need their social security numbers and dates of birth to complete your enrollment.

LOG INTO ADP WORKFORCE NOW

Enrollment must be processed through our ADP Workforce Now Portal. Follow the instructions provided to log into ADP Workforce Now.

- Step 1: Log into ADP site: https://workforcenow.adp.com with your username and password.
  Note: If this is your first time logging in, click **Sign Up**. If you are unsure of the registration code, please contact your manager.
- Step 2: Upon logging in, you will be presented with a pop-up showing important information about this Open Enrollment period. You can click **Start This Enrollment** or **Remind Me Later**. This pop-up is displayed each time you log in during the Open Enrollment period until you complete your selections.
- Step 3: You will be routed to the Enrollments page, where you have the option to either start the Open Enrollment process or review your current benefits.
- Step 4: To start, click **Enroll Now** in the Open Enrollment card. You will be brought back to the Welcome Note and Introduction page. Please review all information on this page, as there are often important references for your Open Enrollment options. If any tobacco attestation requirements are in place, you must provide the information as indicated before clicking **Continue**.
- Step 5: Once you have completed enrollment, review all of your selections. When you have confirmed them, click **Submit Enrollment**. Note that your benefit elections will not be processed until you click **Submit Enrollment**.

MEDICAL INSURANCE

	HSA Basic	PPO Basic	HSA Premium	PPO Premium
Provider Network	Open Access Plus	Open Access Plus	Open Access Plus	Open Access Plus
Calendar Year Deductible				
Individual	$5,000	$5,000	$3,000	$2,000
Family	$5,000 / $10,000	$10,000	$5,000/family ($3,300 per individual max)	$3,000
Coinsurance	10%	30%	0%	20%
Out-of-Pocket Maximum				
Individual	$6,550	$6,350	$3,000	$3,000
Family	$6,550 / $13,100	$12,700	$5,000/family ($3,300 per individual max)	$5,000
COMMON SERVICES				
Inpatient Facility	10% after Deductible	30% after Deductible	0% after Deductible	20% after Deductible
Outpatient Facility	10% after Deductible	30% after Deductible	0% after Deductible	20% after Deductible
Preventive Care	$0	$0	$0	$0
Primary Care Physician	10% after Deductible	$30	0% after Deductible	$25
Specialist	10% after Deductible	$55	0% after Deductible	$50
Urgent Care	10% after Deductible	$60	0% after Deductible	$50
Emergency Room	10% after Deductible	$300	0% after Deductible	$250
LAB AND DIAGNOSTIC TESTING				
Lab / X-Ray	10% after Deductible	$0	0% after Deductible	20% after Deductible
Advanced Imaging	10% after Deductible	30% after Deductible	0% after Deductible	20% after Deductible
OUT-OF-NETWORK BENEFITS				
Deductible				
Individual	$10,000	$10,000	$25,000	$25,000
Family	$20,000	$30,000	$50,000	$50,000
Coinsurance	30%	50%	50%	50%
Out-of-Pocket Maximum				
Individual	$10,000	$20,000	$25,000	$25,000
Family	$20,000	$40,000	$50,000	$50,000

PRESCRIPTION BENEFITS

	HSA Basic	PPO Basic	HSA Premium	PPO Premium
Tier 1	$10 after Deductible	$10	$10 after Deductible	$10
Tier 2	$30 after Deductible	$50	$30 after Deductible	$50
Tier 3	$50 after Deductible	$80	$50 after Deductible	$80

$

Tier 1

Typically generics. Lowest-cost medications that have the same strength and active ingredients as the brand name, but often cost much less – in some cases, up to 85% less.

$$

Tier 2

Typically preferred brand medications. Medium-cost medications. These medications usually cost more than generics, but may cost less than non-preferred brands.

$$$

Tier 3

Higher-cost medications. These medications usually have generic and/or preferred brand alternatives that are used to treat the same condition.

MAIL ORDER RX

With Cigna mail services, you can get your medicines sent right where you want them. Skip driving to the pharmacy and don't wait in line for your prescriptions to be filled. Plain, unmarked packaging protects your privacy. You can receive up to a 90-day supply of long-term medicine at a time. Call 800-244-6224 or visit www.mycigna.com.

TIPS TO HELP YOU SAVE ON YOUR PRESCRIPTION COSTS

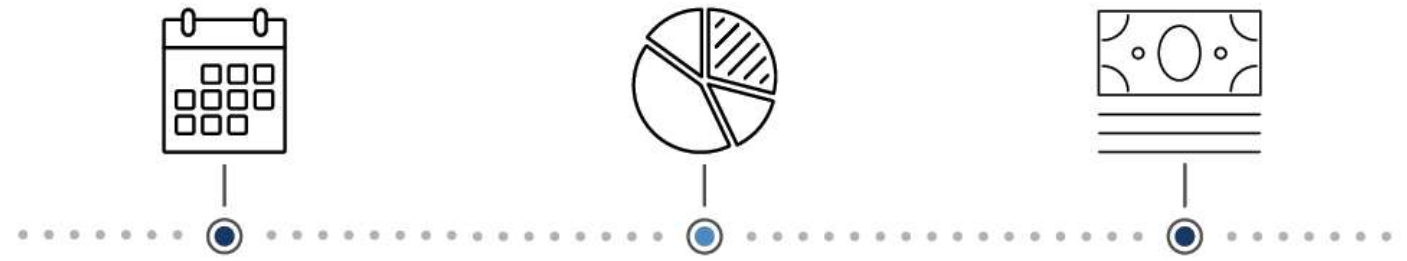
1. **Choose Generic Versions:** Generic medications offer the same effectiveness as brand-name drugs but often come with a significantly lower price tag. You can also utilize price-comparison tools to identify the most cost-effective option for your medications.
2. **Consider Pill Splitting:** Consult with your doctor about the possibility of pill splitting for certain medications. This involves getting a higher-dose prescription and splitting the pills, effectively lowering the cost per dose while maintaining the prescribed dosage.
3. **Stay Informed:** Stay informed about changes in your insurance coverage and prescription drug formularies. Be proactive in discussing alternatives with your healthcare provider if needed.

MEDICAL RATES

BI-WEEKLY (26) DEDUCTIONS

	HSA Basic	PPO Basic	HSA Premium	PPO Premium
Associate Only	$15.37	$94.76	$26.81	$117.23
Associate + Spouse	$177.91	$313.26	$338.10	$439.26
Associate + Child(ren)	$139.08	$241.91	$267.62	$393.07
Associate + Family	$235.45	$405.79	$392.30	$613.12

STEPS TO SELECTING YOUR MEDICAL PLAN



01

Annualize Your Premium

You are responsible for the premium you pay each pay period.

This amount does not change based on your plan utilization.

02

How Do You Use the Plan?

Ask yourself questions such as:

- How often do I go to the doctor?
- Am I anticipating surgery this year?
- What is the most I'm comfortable paying for my healthcare expenses?
- Would it be beneficial to save for future healthcare expenses with an HSA?

03

Estimate Your Expenses

Add your annual premium to your expected medical expenses to estimate your total healthcare costs.

EMPLOYEE ASSISTANCE PROGRAM

uprisehealth

A helping hand when you need it—rely on the support, guidance and resources of your Employee Assistance Program (EAP) from Uprise Health (through Guardian).

The EAP provides confidential counseling, expert guidance and valuable resources to help you and your household members handle any of life's challenges, big or small.

Your program includes 3 telephonic-only counseling sessions– for free! You and your dependents are eligible for counseling services.

Consultations are 100% confidential.

THE EAP CAN HELP WITH SUCH ISSUES AS:

- Stress and Anxiety
- Relationship Issues
- Grief and Loss
- Legal Assistance
- Financial Services
- Childcare Resources
- Senior Care
- Will Prep
- Identity Theft
- and More!

CONNECT TO A COUNSELOR FOR FREE SUPPORT SERVICES

Tel: 800-395-1616

Web: worklife.uprisehealth.com | Username: Matters | Password: wlm70101

TELEMEDICINE

Not feeling your best? Need help with common medical issues like a cold, the flu, allergies, or fever? Get the urgent care you need for minor illnesses 24/7 on demand. You and your household members have access to telemedicine services through Cigna.

The telemedicine benefit is included with your medical coverage. Telemedicine visit costs are HDHP CYD/90% and OAP $30 copay. Additional charges will apply for any medication prescribed during the virtual visit.

Contact Information: 888-726-3171 | www.mycigna.com

WHEN TO USE TELEMEDICINE

Phone and/or video visits can be good choices for follow up care on an existing medical issue, getting or renewing prescriptions, medical advice on minor, non-life threatening conditions such as:

- Sore Throat
- Headache
- Stomachache
- Skin Issues
- Fever
- Cold and Flu
- Allergies
- Diarrhea
- Rash
- Acne
- UTIs
- And More

Remember! Your telemedicine services are best used for minor, non-life-threatening conditions. In an emergency, dial 911 or go to the nearest hospital.

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses or to use as a retirement savings tool.

If you enroll in our high deductible health plan (HDHP), you are eligible to enroll in the HSA offered by Bioderm, Inc (dba Bravida Medical) and administered by Optum Bank.

Bioderm, Inc (dba Bravida Medical) will also contribute to your HSA! See the chart below for the IRS-mandated annual HSA contribution maximums, as well as the company's contribution amounts.

	2026 HSA CONTRIBUTION MAXIMUM (Employer + Associate Funds)	EMPLOYER CONTRIBUTIONS
Individual	$4,400	$500 Annual
Individual + 1 or More	$8,750	$1,000 Annual
Catch-up Contribution (over age 55)	$1,000	N/A

USING YOUR FUNDS

Upon your enrollment, Optum Bank will send you a debit card, which can be used at the time of purchase of HSA-eligible items. The account acts like a regular checking account with a debit card that accrues interest. All money in the account is owned by you and is fully vested as soon as it is deposited. Funds can accumulate over time and the account is portable. Any unused monies left in your HSA at the end of the calendar year will roll over to the next year for you to use.

When you use the funds for qualified health expenses, you will not pay taxes. If you use the money for other expenses, you'll pay a tax and a penalty fee. There are thousands of HSA-eligible items. The list includes, but is not limited to:

- Copays and coinsurance
- Doctor visits and surgeries
- Certain over-the-counter medications
- Dental and orthodontia
- Vision expenses, such as lenses, frames, contacts, etc.

For a complete list of IRS-qualified healthcare expenses, visit irs.gov/publications/p502.

THE NEED TO ENROLL IN OPTUM AND HOW TO DO IT

Opening Your Account

- Visit www.optumbank.com and click Open an HSA.
- Fill out the required information. The group # is 8X2433.
- Your account will take 3-5 business days to process before you can access it.

Next Steps

- After 3-5 business days have passed, you will need to create a HealthSafe ID (username and password). You can do so under Sign In > Account Holder > Register Now.
- Once you've created your credentials, log in and go to Accounts > Account Management – find the area that says Important Account Numbers. **Send the routing and account numbers to the People Department.**
- Optum will mail you a debit card that you can use for doctor's visits, prescriptions, and approved over-the-counter drugs. If you do not receive your debit card 10 business days after you create your account, please call Optum directly at 866-234-8913.

FLEXIBLE SPENDING ACCOUNT

Flexible Spending Accounts (FSAs) are special tax-advantaged accounts used to pay for eligible out-of-pocket healthcare and dependent care expenses. If elected, your account(s) will be funded with tax-free dollars using convenient payroll deductions.

Bioderm, Inc (dba Bravida Medical) offers a Healthcare FSA, Dependent Care FSA, and Limited Purpose FSA, administered by WEX to all benefits-eligible associates.

HEALTHCARE FSA

This plan is used to pay for expenses not covered under your health plans, such as deductibles, coinsurance, copays, and expenses that exceed plan limits.

Additional eligible expenses include: prescriptions, dental work and orthodontia, eye exams, and more!

Contribution Limit: $3,400

LIMITED PURPOSE FSA

This plan is used to pay for eligible vision and dental expenses only.

Unlike a Healthcare FSA, however, this type of FSA account can be held at the same time as a Health Savings Account (HSA).

Contribution Limit: $3,400

DEPENDENT CARE FSA

This plan is used to pay for eligible expenses you incur for your childcare, or for the care of a disabled dependent, while you work.

Eligible expenses include: qualified childcare centers, after school programs, and adult daycare facilities, among others.

Contribution Limit: $7,500 or $3,750 if married, but filing separately

IMPORTANT FSA RULES

A Healthcare FSA cannot be held if you also contribute to an HSA. However, Limited Purpose and Dependent Care FSAs may be held if you also contribute to an HSA.

Medical Expense FSAs: You must forfeit any money left in your account(s) after your expenses for the year have been reimbursed. The IRS does not allow the return of unused account balances at the end of the plan year, and remaining balances cannot be carried forward to a future plan year.

Dependent Care FSA: A Dependent Care FSA distributes its funds on a reimbursement basis. You may be required to provide proof (substantiation) to WEX to prove that the charged expenses were FSA eligible. Unused Dependent Care FSA funds will NOT be returned to you or carried over to the following year. You must incur claims by December 31st of each plan year.

IMPORTANT DATES

Run-out Period: You have a 90-day period at the end of a plan year to claim reimbursement for eligible medical expenses. You have until 3/31/2027 to submit claims for expenses that were incurred on 1/1/2026 through 12/31/2026.

Grace Period: If you have not fully spent the plan year FSA funds, Bioderm, Inc (dba Bravida Medical) permits a “grace period” of 77 days following the end of your plan year for a Healthcare FSA. During the grace period, you may incur expenses and submit manual claims for these expenses. Funds will be automatically deducted from any remaining dollars in your previous plan year's medical FSA balance.

Guardian

DENTAL BENEFITS

In addition to protecting your smile, dental insurance helps pay for dental care and usually includes regular checkups, cleanings and X-rays.

A printed ID card is not needed to receive benefits from dental providers. Members can give their name, carrier, and group policy number (570512) to verify coverage. Should you need an ID card, you can access it online.

	Dental PPO - Low Plan	Dental PPO - High Plan
Network Name	PPO DentalGuard Preferred	PPO DentalGuard Preferred
Individual / Family Deductible	$50 / $150	$50 / $150
Calendar Year Maximum	$1,000	$1,500
Preventive Care	0%	0%
Basic Services	20% after Deductible	20% after Deductible
Major Services	50% after Deductible	50% after Deductible
Endodontic Oral Surgery Covered Under	Basic Services	Basic Services
Periodontic Oral Surgery Covered Under	Basic Services	Basic Services
Orthodontia Benefit Percentage	50%	50%
Orthodontia Lifetime Maximum	$1,000 (Children only, up to age 19)	$1,500 (Children only, up to age 19)
OUT-OF-NETWORK BENEFITS		
Individual / Family Deductible	$50 / $150	$50 / $150
Preventive Services	0%	0%
Basic Services	20% after Deductible	20% after Deductible
Major Services	50% after Deductible	50% after Deductible

BI-WEEKLY (26) DEDUCTIONS

	Dental PPO - Low Plan	Dental PPO - High Plan
Associate Only	$1.74	$3.63
Associate + Spouse	$14.79	$18.78
Associate + Child(ren)	$17.30	$22.07
Associate + Family	$32.88	$40.03

Guardian

VISION BENEFITS

Routine eye exams are just one way you can monitor your health. Conditions like hypertension and diabetes can often be detected by changes in the blood supply to your eyes!

A printed ID card is not needed to receive benefits from vision providers. Members can give their name, carrier, and group policy number (570512) to verify coverage. Should you need an ID card, you can access it online.

	Vision Network Name: VSP Full Feature
EXAM	
Exam Copay	$10
Exam Frequency	Once every calendar year
LENSES	
Lenses Copay	$25
Lenses Frequency	Once every calendar year
FRAMES	
Frames Allowance	$200 Allowance + 20% off balance
Frames Frequency	Once every calendar year
CONTACT LENSES	
Contact Lenses Allowance	Copay waived; $200 Allowance
Contact Lenses Frequency	Once every calendar year
OUT-OF-NETWORK BENEFITS	
Exam Copay	Up to $39
Lenses Copay	Up to $23
Frames Allowance	Up to $46
Contact Lenses Allowance	Copay waived: Up to $100

BI-WEEKLY (26) DEDUCTIONS

Associate Only	$2.42
Associate + Spouse	$5.27
Associate + Child(ren)	$6.10
Associate + Family	$9.38

LIFE AND AD&D INSURANCE

BASIC LIFE AND AD&D

You probably know that life insurance is something that you need to protect your loved ones in the event of your death. Things like funeral expenses, debt, and the cost of living, can all add up. Fortunately, life insurance can help lessen the financial burden and provide coverage to help pay for these types of expenses.

This benefit is 100% paid for by Bioderm, Inc (dba Bravida Medical).

Carrier: Guardian	Benefits
Basic Life Benefit	1 x Salary up to $400,000
Accidental Death & Dismemberment (AD&D) Benefit	1 x Salary up to $400,000
Age Reduction Schedule	By 35% at 65 / by 50% at 70 / by 75% at 75

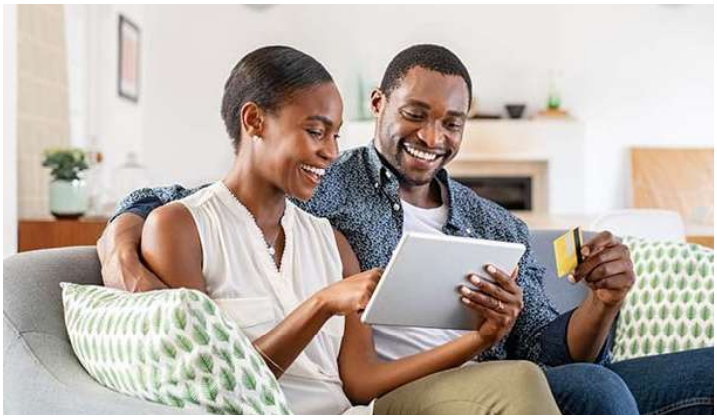
Electing a Beneficiary

It is your responsibility to identify whom should be listed as your beneficiary(ies). You may change your designated beneficiary at any time. Please speak with your financial or legal advisor prior to listing minor children as beneficiaries since children under the age of 18 cannot access life insurance benefits without the proper Trust, UTMA designation, or financial guardian arrangement in effect.

Group Life Portability / Conversion Insurance Policy

If your employment should end you may be able to continue your basic and/or voluntary life insurance under the Group Life Portability/Conversion Insurance Policy without submitting proof of good health. You must contact your employer for the portability/conversion forms and information on how you can apply. You may also contact the carrier member services. Keep in mind that you will have 31 days from the date of termination to submit the appropriate forms directly to the life insurance carrier.

LIFE AND AD&D INSURANCE



VOLUNTARY LIFE AND AD&D

Voluntary Life insurance gives you the opportunity to purchase additional life insurance for you and your family. Your cost per pay period is determined by your election.

To determine your cost per pay period please log in to ADP.

	Benefits
ASSOCIATE	
Increments	$10,000 increments
Maximum Benefit	$250,000
Age Reduction Schedule	65=35%, 70=50%, 75=75%
Guarantee Issue	<65 = $60,000 65-70 = $50,000 70+ = $10,000
SPOUSE	
Increments	$5,000 increments
Maximum	$50,000, not to exceed 100% of Associate Amount
Guarantee Issue	<65 = $30,000 65-70 = $10,000 70+ = $0
DEPENDENT CHILD(REN)	
Increments	$5,000 increments
Maximum	Birth to 2 weeks: $500 2 weeks+: $10,000; not to exceed 10% of Associate Amount
Guarantee Issue	$10,000

What Does Guarantee Issue Mean?

The Guarantee Issue amount means that if you apply for insurance during your initial eligibility period, you're not required to answer health questions to qualify for coverage up to a certain amount.

You and your covered dependents are responsible for completing an Evidence of Insurability (EOI) form if:

- You are electing an amount of coverage greater than the GI amount.
- You waived coverage in the past and now are electing the benefit.
- You are increasing your current election amount.

Open Enrollment Increase Option

Note: Your plan has an Open Enrollment option that allows you to elect an increase of $50,000 to your benefit without requiring that you complete an EOI form, as long as it is under the GI amount. This does not apply to your spouse or dependent children.

Electing a Beneficiary

It is your responsibility to identify whom should be listed as your beneficiary(ies). You may change your designated beneficiary at any time. Please speak with your financial or legal advisor prior to listing minor children as beneficiaries since children under the age of 18 cannot access life insurance benefits without the proper Trust, UTMA designation, or financial guardian arrangement in effect.

Life Portability / Conversion Insurance Policy

You may be able to port/convert the above policies to individual policies, within 31 days of your employment termination with Bioderm, Inc (dba Bravida Medical). Please contact People for details. Any benefit over $50,000 may be subject to imputed income.

DISABILITY INSURANCE

SHORT-TERM DISABILITY

Short-Term Disability (STD) Insurance can help support you and your family should you become temporarily disabled. STD is voluntary and 100% paid for by the associate.

LONG-TERM DISABILITY

Long-Term Disability (LTD) Insurance can protect your income in case of a long-term injury or illness. LTD is 100% paid for by Bioderm, Inc (dba Bravida Medical).

For Employee-Paid Coverage: To determine your per-pay period cost, log in to ADP for customized rates.

Carrier: Guardian	Benefits
SHORT-TERM DISABILITY: ASSOCIATE-PAID	
Benefit Percentage	60%
Maximum Weekly Benefit	$1,500
Elimination Period	Accident: 14 days | Illness: 14 days
Benefit Duration	12 weeks
Pre-Existing Limitation*	3 / 12

*Pre-Existing Condition: if you are treated for a condition 3 months prior to the effective date that results in a disability in first 12 months of coverage, you will not receive benefits. Once you have been covered for 12 months the pre-existing clause no longer applies.

Carrier: Guardian	Benefits
LONG-TERM DISABILITY: EMPLOYER-PAID	
Benefit Percentage	60%
Maximum Monthly Benefit	$10,000
Elimination Period	90 days
Benefit Duration	Social Security Normal Retirement Age
Pre-Existing Limitation**	3 / 12

**Pre-Existing Condition: if you are treated for a condition 3 months prior to the effective date that results in a disability in first 12 months of coverage, you will not receive benefits. Once you have been covered for 12 months the pre-existing clause no longer applies.

Note: For Short-Term Disability coverage, you are responsible for completing an Evidence of Insurability (EOI) form if you waived coverage in the past and are now electing the benefit. It is your responsibility to complete and submit the EOI form to Guardian, and it is recommended you keep a copy for your records.

VOLUNTARY BENEFITS

Guardian

ACCIDENT

Accident Insurance is a voluntary benefit offered through Guardian that pays a lump sum benefit for injuries you or your family may sustain in an accident. To determine your per-pay period cost, log in to ADP for customized rates.

Carrier: Guardian	Benefits
Wellness Benefit	$50
Death Benefit	Associate: $10,000 Spouse: $5,000 Child: $5,000
INITIAL CARE	
Initial Visit	$75
Diagnostic Exam	$100
Urgent Care Visit / Emergency Room Visit	$75 / $150
EMERGENCY TRANSPORTATION	
Ambulance Ground / Ambulance Air	$150 / $750
HOSPITAL SERVICES	
Hospital Admission / Hospital Confinement	$750 / $150
ICU Admission / ICU Confinement	$1,500 / $300 (up to 15 days)

HOSPITAL INDEMNITY

Hospital Indemnity coverage can help you manage out-of-pocket costs that come from being hospitalized if the unexpected should happen. Coverage is also available for your spouse and children. Limitations (including pre-existing conditions) and exclusions apply. For a list of covered services and premium rates, log into ADP. Please see page 31 for an important policy notice about this benefit.

Carrier: Guardian	Benefits
Wellness Benefit	Not Included
SERVICES	
Hospital Admission	$1,000
Hospital Confinement & Stay Duration	$100 per day, up to 31 days per calendar year
ICU Admission	$1,000
ICU Confinement & Stay Duration	$100 per day, up to limited to 31 days per calendar year
Pre-Existing Limitation	N/A

VOLUNTARY BENEFITS

CRITICAL ILLNESS

Critical Illness insurance is a voluntary benefit offered through Guardian that pays out for expenses incurred due to a covered critical illness. To determine your per-pay period cost, log in to ADP for customized rates.

Carrier: Guardian	Benefits
Wellness Benefit	$50
Cancer Benefit	Invasive - 100% / Non-Invasive - 30%
Pre-Existing Limitation*	3/12
EMPLOYEE	
Coverage Increments	$5,000 Increments
Maximum Benefit & Guarantee Issue Amount	$20,000
SPOUSE	
Coverage Increments	50% of Associate Benefit
Maximum Benefit & Guarantee Issue Amount	$10,000
DEPENDENT CHILD(REN)	
Coverage Increments	25% of Associate Benefit
Maximum Benefit & Guarantee Issue Amount	$2,500

*Pre-Existing Condition: if you are treated for a condition 3 months prior to the effective date that results in a disability in first 12 months of coverage, you will not receive benefits. Once you have been covered for 12 months the pre-existing clause no longer applies.

LEGAL INSURANCE

LegalShield offers comprehensive legal assistance, advice and discounted representation on all types of legal services. You'll have access to a network of attorneys who can work with you in-person, over the phone or online to consult with you on legal issues, review and prepare documents, make follow-up calls or write letters on your behalf, represent you if needed, and more.

Coverage includes a spouse/domestic partner, dependents and anyone living in the household. Types of covered legal issues include, but are not limited to:

- Divorce
- Child support, custody, and visitation
- Traffic tickets / Suspended licenses / DUI
- Credit repair
- Loan modifications / Foreclosures
- Wills / Power of Attorney / Trusts
- Identity theft services
- Immigration
- Landlord-Tenant / HOA disputes
- Civil litigations / Small claims
- Personal injury, car accidents, and many more

Payroll Deductions	
Bi-weekly (26)	$10.13

The plan covers the participant, spouse, and dependent children up to age 26.

VOLUNTARY BENEFITS

PET INSURANCE

Pet Benefit Solutions provides a pet health insurance plan that offers reimbursement on accidents and illnesses. You can also choose to add on routine care coverage.

This is a voluntary benefit and you can enroll anytime throughout the year! This is a direct-pay benefit and will not automatically debit from your paycheck.

Each pet's quote is customized based on pet type, breed, age, zip code, reimbursement, and deductible selections.

To enroll, or find out more about coverage options, visit the Pet Benefit Solutions website at www.petbenefits.com.

Carrier: Pet Benefit Solutions	Wishbone - Pet Insurance	Total Pet Plan - Discount Plan
Coverage Type	Accident & Illness coverage (wellness available at additional cost)	Accident, Illness & Wellness Coverage
Type of Pets Covered	Covers Dogs & Cats (from age 7 weeks and older)	Covers all type of pets, dogs, cats horses, ferrets, etc.
Member Savings	90% reimbursement on accident / illness vet bills & Rx	25% Discount at vet bills and up to 40% discount on Rx
Deductibles	$250 Annual Deductible	None
Waiting Period(s)	Short waiting periods apply	None
Claims Process	Submit claim for reimbursement after vet bills are paid	No claims. Save right at the time of purchase/ vet visit
Pre-Existing Conditions	Does NOT cover Pre-Existing Conditions	Covers pre-existing conditions

RETIREMENT BENEFIT

401(K) PLAN

PLAN FEATURES

- **Elective Deferral & Employer Match Eligibility:** 2 months of service
- **Non-elective Contribution Eligibility:** 1 year of service
- **Entry Date:** Monthly
- **Employee Deferrals:** Pre-Tax and Roth
- **Safe Harbor Match:** 100% up to 3% of compensation plus 50% up to the next 2% of compensation
- **Non-elective Contribution:** Discretionary
- **Loans:** Yes
- **In-Service Distributions:** age 59 ½ and hardship

PROFESSIONAL INVESTMENT OPTIONS AND SUPPORT

- On the Web: Log into www.standard.com/retirement. From there you can view your personal account information, learn more about retirement, and change your investment option elections plus more.
- Customer Service:
  - The Standard Customer Service Representative: 800-858-5420, available 8 am through 5 pm in your time zone.
  - Email savings@standard.com
  - Call The Baldwin Group Retirement:

Chriss Spires, Partner
chriss.spires@baldwin.com
904-545-2375

Cathy Howell, Senior Retirement Consultant
cathy.howell@baldwin.com
904-395-8051

EMPLOYER BENEFITS

Access Your Employee Perks Program Today!

working ADVANTAGE

More perks. More savings. More of what makes you happy.

We're here to support your personal and financial well-being through exclusive deals and limited-time offers on the products, services and experiences you need and love.

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Electronics • Appliances • Apparel • Cars • Flowers • Fitness Memberships
Gift Cards • Groceries • Hotels • Movie Tickets • Rental Cars • Special Events
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New to Working Advantage? Getting Started is Easy.

Maximize your time away from the workplace and start saving today!

1. Visit WorkingAdvantage.com
2. Click *Become a Member*
3. Enter your company code or work email to create an account

YOUR COMPANY CODE

BioDerm

Need Help? Email us: customerservice@workingadvantage.com

OTHER PERKS

ASSOCIATE INCENTIVE PROGRAM

If you know someone who would be a good fit for a position at our Company, please refer them to our website to apply at biodermInc.com ➔ Careers ➔ Join Our Team. Please ensure they list your name in the space provided in the ADP portal.

{$500.00} referral incentive after 90-days of satisfactory employment

- All Full-Time & Part-Time associates are eligible to participate, except:
  - Senior Leadership (CEO, VP, Directors);
  - Company Recruiters and direct Hiring Managers with positions to fill in their own departments;
  - Temporary, seasonal or contract staffer roles are not eligible.
- There is no limit on the number of qualified candidates that you may refer.
- If two or more employees refer the same candidate, only the first referrer will receive their referral incentive.

This program is subject to change or discontinuance any time.

Let's refer away!

MILESTONE RECOGNITION

In addition to PTO accruals, regular cook-outs, and fun events we also honor our employees longevity with the Company.

You are a "Shining Star" glass trophy and $100 gift.

You are a "Shining Star" glass trophy and $200 gift.

You are a "Shining Star" glass trophy and $300 gift.

You are a "Shining Star" glass trophy and $400 gift.

You are a "Shining Star" glass trophy and $500 gift.

OTHER PERKS

RETROACTIVE TO OCTOBER 1, 2024

Objective

We value associates with exemplary attendance and recognize eligible **full-time** and **part-time** hourly associates on a quarterly basis. Additionally, this program provides hourly associates an opportunity to earn additional income while maintaining their productivity standards.

Who is eligible

- All hourly associates at Geneva.
- All hourly associates at Largo.
- All hourly associates at Yorkville.
- **Exempt; salaried associates are not eligible for this program.**
- **Seasonal, on-call and/or PRN associates are not eligible for this program.**

To receive an attendance incentive, the associate must have been a **full-time or part-time** employee during the **previous 90-days** and has not used sick time, taken no time off without pay, had no absence for disciplinary reasons, had no unscheduled late arrivals **(7-minute grace period)** or unscheduled early departures, and had no unscheduled PTO.

The following approved absences will not be counted against perfect attendance:

- Absences designated as FMLA, FMLI, Military, Jury Duty or other protected leaves in accordance with Federal or State Law.
- Pre-approved PTO or observed holidays in accordance with company policy.
- Time off due to work-related activities (conferences, training, education etc.).
- Up to 3-days bereavement leave in accordance with company policy.

Incentive

The hourly associate must be actively employed on the day of distribution. The award is a two hundred and fifty dollar **($250.00)** incentive distributed on the following schedule below:

- Quarter close **March**, distributed → **April-1 payroll.**
- Quarter close **June**, distributed → **July-1 payroll.**
- Quarter close **September**, distributed → **October-1 payroll.**
- Quarter close **December**, distributed → **January-1 payroll.**

Please contact the People Department if you have any questions. **11/20/2024**

FEDERAL GUIDELINES

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

AFFORDABLE CARE ACT (ACA) HEALTHCARE REFORM EXCHANGE NOTICE Under ACA, large employers are responsible to provide eligible associates with coverage that meets the affordability and actuarial value rules set by our government. The plans offered by your employer meet these standards. You will receive a separate notice with specific information. As a result, you and/or your dependents may not be eligible for a federal or state subsidy when applying for coverage in the Healthcare Marketplace.

HIPAA–PRIVACY ACT LEGISLATION The Health Plan and your health care carrier(s) are obligated to protect confidential health information that identifies you or could be used to identify you as it relates to a physical or mental health condition or payment of your health care expenses. If you elect new coverage, you and your beneficiaries will be notified of the policies and practices to protect the confidentiality of your health information.

WOMEN'S HEALTH AND CANCER RIGHTS ACT The Women's Health and Cancer Rights Act (WHCRA) includes protections for individuals who elect breast reconstruction in connection with a mastectomy. WHCRA provides that group health plans provide coverage for medical and surgical benefits with respect to mastectomies. It must also cover certain post-mastectomy benefits, including reconstructive surgery and the treatment of complications (such as lymphedema). Coverage for mastectomy-related services or benefits required under the WHCRA are subject to the same deductible and coinsurance or copayment provisions that apply to other medical or surgical benefits your group contract provides.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA) OF 2008 Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and associates from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, associates, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, associates, or their family members.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996
The Newborns' and Mothers' Health Protection Act of 1996 provides that group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with child birth 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). An attending provider is defined as an individual who is licensed under applicable state law to provide maternal or pediatric care and who is directly responsible for providing such care to a mother or newborn child. The definition of attending provider does not include a plan, hospital, managed care organization or other issuer. In any case, plans may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Please contact us if you would like any additional information on The Newborns' and Mothers' Health Protection Act or WHCRA.

MICHELLE'S LAW An amendment to the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC). This law ensures that dependent students who take a medically necessary leave of absence do not lose health insurance coverage. Michelle's Law allows seriously ill college students, who are covered dependents under health plans, to continue coverage for up to one year while on medically necessary leaves of absence. The leave must be medically necessary as certified by a physician, and the change in enrollment must commence while the dependent is suffering from a serious illness or injury and must cause the dependent to lose student status. Under the law, a dependent child is entitled to the same level of benefits during a medically necessary leave of absence as the child had before taking the leave. If any changes are made to the health plan during the leave, the child remains eligible for the changed coverage in the same manner as would have applied if the changed coverage had been the previous coverage, so long as the changed coverage remains available to other dependent children under the plan.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994 (USERRA) The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) was signed into law on October 13, 1994. USERRA clarifies and strengthens the Veterans' Reemployment Rights (VRR) Statute. The Act itself can be found in the United States Code at Chapter 43, Part III, Title 38. The Department of Labor has issued regulations that clarify its position on the rights of returning service members to family and medical leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA). See 20 CFR Part 1002.210. USERRA is intended to minimize the disadvantages to an individual that occur when that person needs to be absent from his or her civilian employment to serve in this country's uniformed services. USERRA makes major improvements in protecting service member rights and benefits by clarifying the law and improving enforcement mechanisms. It also provides associates with Department of Labor assistance in processing claims. USERRA covers virtually every individual in the country who serves in or has served in the uniformed services and applies to all employers in the public and private sectors, including Federal employers. The law seeks to ensure that those who serve their country can retain their civilian employment and benefits, and can seek employment free from discrimination because of their service. USERRA provides protection for disabled veterans, requiring employers to make reasonable efforts to accommodate the disability. USERRA is administered by the United States Department of Labor, through the Veterans' Employment and Training Service (VETS). VETS provides assistance to those persons experiencing service connected problems with their civilian employment and provides information about the Act to employers. VETS also assists veterans who have questions regarding Veterans' Preference.

YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")? When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

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

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

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Help desk at the Centers for Medicare and Medicaid Services at 800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

If applicable, visit your state's website for more information about your rights under applicable state laws.

FEDERAL GUIDELINES

HIPAA SPECIAL ENROLLMENT NOTICE

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

Loss of Other Coverage: If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 30 days of the date coverage ends, you and your eligible dependents may apply for coverage under this health plan.

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

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this group health plan. However, you must apply within 30 days from the date of your marriage.

Medicaid or CHIP: If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP and you did not enroll them in this health plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this group health plan if you apply within 60 days of the date of their loss of CHIP coverage. For more information or assistance to request special enrollment or obtain more information, please contact:

Kevin Goyer

8250 Bryan Dairy Rd, Suite 130

Largo, FL 33777

727-507-7655

Note: If you or your dependents enroll during a special enrollment period, as described above, you will not be considered a late enrollee. Therefore, your group health plan may not impose a pre-existing condition exclusion period of more than 12 months. Any pre-existing condition exclusion period will be reduced by the amount of your prior creditable health coverage. Effective for plan years beginning on or after January 1, 2014, health plans may not impose pre-existing condition exclusions on any enrollees.

HITECH (FROM WWW.CDC.GOV) The American Reinvestment & Recovery Act (ARRA) was enacted on February 17, 2009. ARRA includes many measures to modernize our nation's infrastructure, one of which is the "Health Information Technology for Economic and Clinical Health (HITECH) Act". The HITECH Act supports the concept of electronic health records - meaningful use [EHR-MU], an effort led by Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health IT (ONC). HITECH proposes the meaningful use of interoperable electronic health records throughout the United States health care delivery system as a critical national goal. Meaningful Use is defined by the use of certified EHR technology in a meaningful manner (for example electronic prescribing); ensuring that the certified EHR technology is connected in a manner that provides for the electronic exchange of health information to improve the quality of care; and that in using certified EHR technology the provider must submit to the Secretary of Health & Human Services (HHS) information on quality of care and other measures.

RESCISSIONS: The Affordable Care Act prohibits the rescission of health plan coverage except for fraud or intentional misrepresentation of a material fact. A rescission of a person's health plan coverage means that we would treat that person as never having had the coverage. The prohibition on rescissions applies to group health plans, including grandfathered plans, effective for plan years beginning on or after September 23, 2010.

Regulations provide that a rescission includes any retroactive terminations or retroactive cancellations of coverage except to the extent that the termination or cancellation is due to the failure to timely pay premiums. Rescissions are prohibited except in the case of fraud or intentional misrepresentation of a material fact. For example, if an associate is enrolled in the plan and makes the required contributions, then the associate's coverage may not be rescinded if it is later discovered that the associate was mistakenly enrolled and was not eligible to participate. If a mistake was made, and there was no fraud or intentional misrepresentation of a material fact, then the associate's coverage may be cancelled prospectively but not retroactively.

Should a member's coverage be rescinded, then the member must be provided 30 days advance written notice of the rescission. The notice must also include the member's appeal rights as required by law and as provided in the member's plan benefit documents. Please be aware that if you rescind a member's coverage, you must provide the proper notice to the member.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA): MHPAEA generally applies to group health plans and health insurance issuers that provide coverage for both mental health or substance use disorder benefits and medical/surgical benefits. MHPAEA provides with respect to parity in coverage of mental health and substance use disorder benefits and medical/surgical benefits provided by employment-based group health plans. MHPA '96 required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits. MHPAEA expands those provisions to include substance use disorder benefits. Thus, under MHPAEA group health plans and issuers may not impose a lifetime or annual dollar limit on mental health or substance use disorder benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. MHPAEA also requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles), and quantitative treatment limitations (such as visit limits), applicable to mental health or substance use disorder benefits are generally no more restrictive than the requirements or limitations applied to medical/surgical benefits. The MHPAEA regulations also require plans and issuers to ensure parity with respect to no quantitative treatment limitations (such as medical management standards).

PREVENTIVE CARE: Health plans will provide in-network, first-dollar coverage, without cost-sharing, for preventive services and immunizations as determined under health care reform regulations. These include, but are not limited to, cancer screenings, well-baby visits and influenza vaccines. For a complete list of covered services, please visit:
www.healthcare.gov/coverage/preventive-care-benefits/

WELLNESS PROGRAM (if applicable): Our company's Wellness Program is a voluntary wellness program available to all associates. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve associate health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

FEDERAL GUIDELINES

HIPAA NOTICE OF PRIVACY NOTICE

"We" & "Us" throughout this notice indicates information held by the insurance carrier or for self-funded plans, the TPA.

Your Information. Your Rights. Our Responsibilities.

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

Your Rights

You have the right to:

- Get a copy of your health and claims records

- Correct your health and claims records

- Request confidential communication

- Ask us to limit the information we share

- Get a list of those with whom we've shared your information

- Get a copy of this privacy notice

- Choose someone to act for you

- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends

- Provide disaster relief

- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive

- Run our organization

- Pay for your health services

- Administer your health plan

- Help with public health and safety issues

- Do research

- Comply with the law

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- Address workers' compensation, law enforcement, and other government requests

- Respond to lawsuits and legal actions

SUD Treatment Information: If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purposes of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct health and claims records if you think is incorrect or incomplete. Ask us how to do this.

- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.

- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting your plan administrator.

- You can file a complaint with the U.S. Dept. of Health and Human Services Office for Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care

- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes

- Sale of your information

(continued on next page.)

FEDERAL GUIDELINES

HIPAA NOTICE OF PRIVACY NOTICE

(cont.)

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.

- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease

- Helping with product recalls

- Reporting adverse reactions to medications

- Reporting suspected abuse, neglect, or domestic violence

- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims

- For law enforcement purposes or with a law enforcement official

- With health oversight agencies for activities authorized by law

- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request or in our office.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Dear Employee, Spouse and Dependent Children:

We have been retained by your sponsoring employer to provide you with information concerning your rights under COBRA. You are receiving this notice because you have recently become covered or will become covered under your sponsoring employer's group health plan ("the Plan"). **This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.**

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. This notice only gives a summary of your continuation coverage rights under the Plan. For additional 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 or the COBRA administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as 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 a qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

· Your hours of employment are reduced, or

· Your employment ends for any reason other than your gross misconduct.

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

· Your spouse dies;

· Your spouse's hours of employment are reduced;

· Your spouse's employment ends for any reason other than their 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 any of the following qualifying events happens:

· The parent-employee dies;

· The parent-employee's hours of employment are reduced;

· The parent-employee's employment ends for any reason other than their gross misconduct;

· The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);

· The parents become divorced or legally separated; or

· The child stops being eligible for coverage under the Plan as a "dependent child."

Qualified beneficiaries also include a child born to or placed for adoption with the covered employee who satisfies the plan eligibility requirements and becomes covered under the Plan during the period of COBRA coverage.

Retirees

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the sponsoring employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the COBRA administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the 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) causing a loss of coverage, you must notify the COBRA administrator in writing within 60 days after the later of the date the qualifying event occurs or the date that you would lose benefits due to a qualifying event. The employee or family member can provide notice on behalf of themselves as well as other family members affected by the qualifying event. The written notice of the qualifying event should be sent to the COBRA administrator and should include all of the following:

- Date (month/day/year)
- Spouse/Dependent's Name
- Social Security Number/ID#
- Spouse/Dependent's Address
- Spouse/Dependent's Telephone #
- Gender
- Date of Birth (month/day/year)
- Relationship to Employee
- Employer's Name
- Employee's Name
- Employee's SSN/ID#
- Reason for Loss of Coverage
- Loss of Coverage (month/day/year)

If you need help acting on behalf of an incompetent beneficiary, please contact the COBRA administrator for assistance.

How is COBRA Coverage Provided?

Once the COBRA 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. You will not have to show that you are insurable to choose continuation coverage. However, you will have to pay the group rate premium for your continuation coverage plus a 2% administration fee, if applicable.

How long does COBRA coverage last?

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. However, if the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for the spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). There are two ways in which an 18-month period of COBRA continuation coverage can be extended:

1) Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA vendor in writing in a timely fashion, you and your entire family may be entitled to receive an additional 11 months of COBRA continuation coverage for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. The qualified beneficiary must provide the written determination of disability from the Social Security Administration to the COBRA administrator within 60 days of the latest of the date of the disability determination by the Social Security Administration, the date of the qualifying event or the benefit termination date; and prior to the end of the 18-month COBRA continuation period. You will be required to pay up to 150% of the group rate during the 11- month extension.

2) Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 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 notice of the second qualifying event is properly given to the COBRA administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan should be addressed to the Plan Administrator of the sponsoring employer. Questions concerning your COBRA continuation coverage rights should be addressed to the COBRA administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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 the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Please Note

Some states offer financial aid to help certain individuals pay for COBRA coverage. Contact your appropriate state agency regarding availability and eligibility requirements. Additionally, under certain circumstances, COBRA coverage may be paid with pre-tax dollars from a cafeteria plan under Section 125.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator and the COBRA administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to either the Plan Administrator or the COBRA administrator.

MEDICARE PART D: CREDITABLE COVERAGE

Important Notice from Bioderm, Inc (dba Bravida Medical) 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 Bioderm, Inc (dba Bravida Medical) 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 and 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. Bioderm, Inc (dba Bravida Medical) has determined that the prescription drug coverage offered by Cigna are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Bioderm, Inc (dba Bravida Medical) coverage will not be affected. You can keep this coverage if you elect part D and Cigna will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Bioderm, Inc (dba Bravida Medical) provided coverage, be aware that you and your dependents may not 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 Bioderm, Inc (dba Bravida Medical) 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.

More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	1/1/2026
Name of Entity:	Bioderm, Inc (dba Bravida Medical)
Contact:	Kevin Goyer
Address:	8250 Bryan Dairy Rd, Suite 130 Largo, FL 33777
Phone:	727-507-7655

SUMMARY PLAN DESCRIPTION

Please note this guide is designed to provide an overview of the coverages available. Your employer reserves the right to amend or change benefit offerings at any time. This guide is not a Summary Plan Description (SPD) nor a contract or guarantee of benefits coverage. Official plan and insurance documents govern your rights and benefits, including covered benefits, exclusions and limitations. If any discrepancy exists between this guide and the official documents, the official documents will prevail. If you would like a printed copy of the materials, please contact your employer or the Employee Care Center (ECC) and one will be provided to you.

SUMMARY OF BENEFIT COVERAGE

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) requires health plans and health insurance issuers to provide a Summary of Benefits and Coverage (SBC) to applicants and enrollees. The SBC is provided by your medical carrier. Its purpose is to help health plan consumers better understand the coverage they have and to help them make easy comparisons of different options when shopping for new coverage. This information is available when you apply for coverage, by the first day of coverage (if there are any changes), when your dependents are enrolled off your annual Open Enrollment period, upon plan renewal and upon request at no charge to you.

VIEW YOUR BENEFITS ON THE GO

Guide Prepared By:

The Baldwin Group