BRIGHTSPRING REQUIRED NOTICES

ResCare, Inc. d/b/a BrightSpring Health Services reserves the right to change, amend, or terminate any benefit plan at any time for any reason. Participation in a benefit plan is not a promise or guarantee of future employment. Receipt of benefit documents does not constitute eligibility.

SUMMARY OF BENEFITS COVERAGE

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health plan is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. The SBC is available on the web at www.brightspringbenefits.com or by accessing the BrightSpringConnect app. A paper copy is also available, free of charge, by calling the Benefits Support Center at (844) 896-0169 or emailing BrightSpringBenefits@BrightSpringHealth.com.

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides employees additional opportunities outside of open enrollment, to enroll in a group health plan if they experience a loss of other coverage or for certain life events. If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible 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 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

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

To request HIPAA special enrollment or obtain more information, contact the BrightSpring Benefits Support Center at (844) 896-0169.

WOMEN'S HEALTH AND CANCER RIGHTS

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the BrightSpring group health plan. If you would like more information

on WHCRA benefits, call the Benefits Support Center at (844) 896-0169.

BRIGHTSPRING HIPAA PRIVACY NOTICE

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.

This notice applies to all self-funded group health benefits (referred to as the "Plan") sponsored by Res-Care, Inc. d/b/a BrightSpring Health Services (the "Plan Sponsor") and is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. The purpose of this Notice is to inform you of the Plan's privacy practices.

In connection with providing health benefits to you, the Plan receives and maintains medical and other information about you. The Plan is sponsored by Res-Care, Inc d/b/a BrightSpring Health Services (the "Plan Sponsor"). The Plan Sponsor has hired Imagine 360 to process claims and otherwise assist with Plan operations. The Plan Sponsor may also hire other service providers to assist with Plan operations. These service providers are called "business associates" of the Plan, and the Plan Sponsor requires that they agree to comply with the privacy laws regarding your protected health information. The Plan Sponsor or your employer may also assist with Plan operations as described below, and the Plan Sponsor and your employer will comply with the privacy laws with respect to your protected health information if they maintain or receive any such information.

HIPAA does not apply to information maintained by your employer other than in connection with the Plan. Information provided to your employer by you or from another source that is in connection with sick or disability pay, a leave of absence, or a benefit plan that is not a health plan is not subject to these rules.

The Plan's Obligations.

The Health Plan is required by law to:

- Make certain that your protected health information (PHI) is safeguarded and used or disclosed only in accordance with HIPAA and the provisions of this notice;
- Give you this notice of your legal rights with respect to your PHI, and the Plan's legal duties and privacy practices with respect to health information about you;
- Notify you following a breach of your unsecured PHI; and
- Follow the terms of the notice that are in effect.

How the Plan Uses Your Protected Health Information.

The Plan may use and disclose your protected health information for the following purposes:

Claims Payment. The Plan may use or disclose your protected health information to process and pay a claim for services or supplies covered by the Plan. The Plan may also provide eligibility information to your doctor or another provider who requests the information in connection with your treatment.

Operation of the Plan. The Plan may use or disclose your medical information in connection with its normal operations and management, such as conducting quality assessment and improvement activities, underwriting or other activities relating to insurance in connection with the Plan, care coordination or case management, customer service, and fraud detection. However, genetic information cannot be used for underwriting purposes.

Treatment Purposes. The Plan may disclose your medical information to your doctor, at the doctor's request, in connection with your treatment. The Plan may also use your medical information to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Disclosure Required by Law. The Plan must disclose protected health information to the U.S. Department of Health and Human Services in connection with an audit. The Plan may also disclose your medical information as required to comply with workers' compensation laws, or as required by a legal proceeding, such as a court or administrative order or subpoena.

To Your Employer. The Plan may disclose to your employer summary claims and other similar information if information that could be used to identify individuals has been removed. Such summary information does not disclose your name or other distinguishing characteristics. The Plan may also disclose to your employer whether you are enrolled in the Plan. The Plan may disclose your protected health information to the Plan Sponsor or to your employer for Plan administrative functions as long as the Plan Sponsor or your employer (as the case may be) has certified that it will ensure the continuing confidentiality and security of your protected health information and that it will not use or disclose your medical information for employment-related activities or for any other benefit or benefit plans of the Plan Sponsor or employer. The Plan Sponsor has amended the Plan to specifically allow this use for Plan purposes by the Plan Sponsor or your employer.

To Family Members. The Plan may generally disclose protected health information to a spouse or parent in connection with inquiries about plan benefits and claims payment. An individual (but not an unemancipated minor) may ask that no such disclosure be made to family members, and the Plan will honor the request. The Plan may require a written authorization before making disclosures to a family member. A Plan may disclose protected health information to a family member, friend or other person, for the purpose of helping you with your health care or with payment for your health care, if you are in a situation such as a medical emergency and you are not able to give or withhold consent for the Plan to do this.

Business Associates. The Plan may disclose your protected health information to third parties with whom it contracts to perform services on its behalf. If the Plan disclose your information to these entities, it will have an agreement with them to safeguard your information. Examples of these third parties include, but are not limited to, third party administrators, auditors, etc.

Communications with You. The Plan, or its business associates, may contact you via telephone, email, or text message about your treatment, care, or payment related activities. As an example, the Plan may remind you that you have an appointment for medical care and provide information about treatment. The Plan or its business associate may also use your protected health information to communicate with you about health-related benefits or services that may be of interest to you, such as available immunizations.

Legal Proceedings, Lawsuits and Other Legal Actions. The Plan may disclose protected health information about you to courts, attorneys, court employees, and others when we receive a court order, administrative subpoena, warrant, or other lawful instructions. The Plan also may disclose protected health information about you to those working on the Plan's behalf in a lawsuit or action involving the Plan. The Plan may also disclose information for law enforcement purposes as required by law or in response to a valid administrative subpoena, court order, or similar process.

Substance use disorder treatment records received from programs subject to 42 CFR part 2, or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against you unless based on written consent, or a court order after notice and an opportunity to be heard is provided to you or the holder of the record. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Other Uses. The Plan may also use and disclose your medical information as follows:

- The Plan may disclose protected health information to the extent required by law, to law enforcement officials, the U.S. Armed Forces, for research, for national security, or for public health activities as permitted by the privacy laws.
- The Plan may disclose protected health information about a deceased person to a coroner, medical examiner, or funeral director.
- The Plan may disclose protected health information in the event of a serious threat to your health or safety or the health or safety of others.
- If the Plan reasonably believes that you are a victim of abuse, neglect or domestic violence, the Plan may disclose PHI about you to a government authority, including a social services or protective

services agency, authorized by law to receive such reports.

- If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- To workers' compensation agencies for workers' compensation benefit determination.
- To another health plan maintained by the Plan Sponsor for purposes of facilitating claims payments under that plan.

You Must Authorize Other Uses. The Plan (including business associates providing services to the Plan and your employer) will not use or disclose your protected health information from the Plan for any purpose other than those described in this Notice unless you give the Plan written authorization to do so. With limited exceptions, the Plan must obtain your authorization for uses or disclosures of psychotherapy notes, protected health information used for marketing purposes, and sales of protected health information. If you give written authorization, it must state the specific use you are authorizing, and in most cases, you may revoke your authorization in writing at any time. Your revocation will not be effective to the extent that the Plan has already taken action in reliance on your authorization. The Plan is prohibited from using or disclosing any of your PHI that is genetic information for underwriting purposes.

Individual Rights to Inspect, Copy, and Amend and Other Rights Regarding Health Information.

The law gives you certain rights regarding your protected health information used or maintained by the Plan, as follows:

- You have the right to see and get copies of your protected health information, with limited exceptions. The Plan reserves the right to impose a reasonable charge for paper copies, repeat disclosures or numerous disclosure requests within one year.
- You have the right to ask that the Plan communicate with you in another way to keep your protected health information confidential. You can ask the Plan to communicate by a different means or at a different location than the Plan normally uses. The Plan does not have to agree to your request unless such confidential communications are necessary to avoid endangering you and your request continues to allow the Plan to collect premiums and pay claims.
- You may request additional restrictions on the Plan's use and disclosure of your medical information. The Plan does not have to agree to your request. However, the Plan must comply with your request not to disclose information about any medical expense for which you paid in full for the services.
- You have the right to notice in the event of an unauthorized disclosure of your health information where there is a significant risk your information has been compromised.
- You may request a correction to your protected health information. The Plan will determine whether it is appropriate to correct your information in a particular circumstance.
- You may request an accounting of disclosures of your medical information by the Plan for the last 6 years. This accounting will not include disclosures for treatment, payment or Plan operations, disclosures to you, disclosures pursuant to your authorization, or disclosures for disaster relief, national security, or intelligence purposes.
- You may request a paper copy of this notice if you received this notice by e -mail or on the internet.

If you want to exercise any of the above rights, contact the Privacy Official of the Plan as described below.

State Privacy Rights. You may have additional health information privacy rights under state laws, including rights in connection with mental health and psychotherapy reports, pregnancy, HIV/AIDS-related illnesses, and the health treatment of minors.

Complaints. You have the right to complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services if you believe that your rights regarding the privacy of your protected health information have been violated. You may file a complaint with the Plan's Information and Complaint Official (identified below). You will not be retaliated against if you choose to file a complaint with the Plan or

with the U.S. Department of Health and Human Services.

Privacy Official and Information and Complaint Official. For more information about the Plan's privacy practices or to take advantage of your rights as described in this Notice, contact:

Privacy Officer
BrightSpring Health Services
805 N Whittington Parkway
Louisville, KY 40222

To file a complaint with the plan, contact:

Privacy Officer
BrightSpring Health Services
805 N Whittington Parkway
Louisville, KY 40222
502-394-2100

To file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:
200 Independence Avenue, S.W.
Washington, D.C. 20201

Effective Date of This Notice. This Notice is effective as of October 1, 2025. The Plan must comply with the provisions in this Notice until it is changed. The Plan reserves the right to change the provisions of this Notice at any time. If the Plan makes changes to this Notice, the Plan will send the changed Notice to all participants covered by the Plan at that time. The Plan may make the changes that apply to all protected health information it maintains, even information obtained before the effective date of the new Notice.

Interpretation. This notice is intended to comply with the privacy provisions of the Health Insurance Portability and Accountability Act (HIPAA). It is not intended to give individuals any greater rights than they have under HIPAA and it is not intended to give the Plan, employers or business associates any greater obligations than they have under HIPAA, and it shall be interpreted accordingly. However, state laws may provide additional protections, in which case those additional protections will apply.

CREDITABLE COVERAGE DISCLOSURE NOTICE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with BrightSpring and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan.

If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

    - Imagine360 $3,500 Plan with Co-Pay
    - Imagine360 $4,500 HDHP
    - Kaiser Colorado $1,500 HMO
    - Kaiser Colorado $3,400 HDHP
    - Kaiser California $1,500 HMO
    - Kaiser California $3,400 HDHP
    - Kaiser Washington $1,500 HMO
    - Kaiser Washington $2,500 HDHP
    - Kaiser Northwest $1,500 HMO
    - Kaiser Northwest $3,400 HDHP

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?

Your BrightSpring coverage pays for other medical expenses in addition to prescription drugs. If you or your covered family member for whom Medicare pays second enrolls in a Medicare drug plan, your BrightSpring medical and prescription drug coverage will not be impacted, and the Medicare drug benefits will be coordinated with your BrightSpring prescription drug plan coverage. Medicare drug coverage will be secondary for you or the covered family member who chooses to enroll in a Medicare drug plan. However, you will have to pay a Medicare Part D premium, which BrightSpring will not reimburse.

Because your existing coverage is considered Creditable Coverage, you have several options. Your options include the following:

- Maintain your current benefits with BrightSpring and delay enrollment in Medicare prescription drug coverage.
- Keep your current benefits with BrightSpring and enroll in Medicare prescription drug coverage (in addition to prescription drugs, your current coverage includes medical benefits through the plan options listed above and you will be eligible to receive all of your current medical benefits even if you choose to enroll in a Medicare prescription drug plan).
- Enroll in a Medicare prescription drug plan and drop current benefits with BrightSpring. Note that you will lose your BrightSpring medical

coverage as well as prescription drug coverage if you elect this option.

Medicare drug plans are required to pay a high percentage of covered prescription drug costs once you reach a certain out of pocket maximum amount each year. If you have both Medicare and BrightSpring prescription drug coverage, the amounts covered by BrightSpring prescription drug coverage will delay, and may prevent, you from reaching this limit. So, before you enroll in a Medicare drug plan, you should consider whether it will provide you with additional value.

If you do decide to join a Medicare drug plan and drop your current BrightSpring coverage, be aware that you and your dependents may not be able to get this coverage back until the next open enrollment period or if you experience a qualifying life event that allows for a mid-year election.

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 BrightSpring 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 BrightSpring Benefits Support Center at (844) 896-0169. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the BrightSpring changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

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

Date of this notice: October 1, 2025

BrightSpring Health Services
Benefits Department
805 N. Whittington Parkway
Louisville, KY 40222

NON-CREDITABLE COVERAGE DISCLOSURE NOTICE

IMPORTANT NOTICE FROM BRIGHTSPRING HEALTH SERVICES 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 BrightSpring Health Services 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. BrightSpring Health Services has determined that the prescription drug coverage offered by the **UHC FlexWork Plan** is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the **UHC FlexWork Plan**. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can elect to keep coverage from the **UHC FlexWork Plan**. However, because this coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a Medicare drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 decide to drop your current coverage with BrightSpring Health Services, since it is employer-sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; However, you also may pay a higher premium (a penalty) because you did not have creditable coverage under the **UHC FlexWork Plan**.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Since the coverage under the **UHC FlexWork Plan**, is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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 BrightSpring coverage will not be affected, and the Medicare drug benefits will be coordinated with your BrightSpring coverage. As an active employee, Medicare drug coverage will pay secondary for you or your spouse who chooses to enroll in a Medicare drug plan. However, you likely will have to pay a Medicare Part D

premium, which BrightSpring will not reimburse. Your options include the following:

- Keep your current benefits with BrightSpring Health Services and enroll in Medicare prescription drug coverage (in addition to prescription drugs, your current coverage includes medical benefits through the plans listed above and you will be eligible to receive all of your current medical benefits even if you choose to enroll in a Medicare prescription drug plan).
- Enroll in a Medicare prescription drug plan and drop current benefits with BrightSpring Health Services. Note that you will lose your BrightSpring medical coverage as well as prescription drug coverage if you elect this option.

If you do decide to join a Medicare drug plan and drop your current BrightSpring Health Services coverage, be aware that you and your dependents may not be able to get this coverage back until the next open enrollment period or you experience a qualified life event that allows for a mid-year enrollment.

For More Information About This Notice Or Your Current Prescription Drug Coverage: Contact the BrightSpring Benefits Support Center at (844) 896-0169. 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 BrightSpring Health Services changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage: More detailed information about Medicare plans that offer prescription drug coverage can be found 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).

Date of this notice: October 1, 2025

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, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW (1-877-543-7669) or visit 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 U.S. Department of Labor's Employee Benefits Security Administration 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, 2025. 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:

https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/

Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website:

http://dhcs.ca.gov/hipp

Phone: 916-445-8322

Fax: 916-440-5676

Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado

(Colorado's Medicaid Program) & Child Health

Plan Plus (CHP+)

Health First Colorado Website:

https://www.healthfirstcolorado.com/

Health First Colorado Member Contact Center:

1-800-221-3943/State Relay 711

CHP+: https://hcpf.colorado.gov/child-health-plan-plus

CHP+ Customer Service: 1-800-359-1991/State Relay 711

Health Insurance Buy-In Program (HIBI):

https://www.mycohibi.com/

HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website:

https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html

Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp

Phone: 678-564-1162, Press 1

GA CHIPRA Website:

https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra

Phone: 678-564-1162, Press 2

INDIANA – Medicaid

Health Insurance Premium Payment Program

All other Medicaid

Website: https://www.in.gov/medicaid/

http://www.in.gov/fssa/dfr/

Family and Social Services Administration

Phone: 1-800-403-0864

Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:

Iowa Medicaid | Health & Human Services

Medicaid Phone: 1-800-338-8366

Hawki Website:

Hawki - Healthy and Well Kids in Iowa | Health & Human Services

Hawki Phone: 1-800-257-8563

HIPP Website: Health Insurance Premium Payment (HIPP) |

Health & Human Services (iowa.gov)

HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/

Phone: 1-800-792-4884

HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment

Program (KI-HIPP) Website:

https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx

Phone: 1-855-459-6328

Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kynect.ky.gov

Phone: 1-877-524-4718

Kentucky Medicaid Website:

https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp

Phone: 1-888-342-6207 (Medicaid hotline) or

1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website:

https://www.mymaineconnection.gov/benefits/s/?language=en_US

Phone: 1-800-442-6003

TTY: Maine relay 711

Private Health Insurance Premium Webpage:

https://www.maine.gov/dhhs/ofi/applications-forms

Phone: 1-800-977-6740

TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa

Phone: 1-800-862-4840

TTY: 711

Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website:

https://mn.gov/dhs/health-care-coverage/

Phone: 1-800-657-3672

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

Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov

Phone: 1-855-632-7633

Lincoln: 402-473-7000

Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov

Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-

services/medicaid/health-insurance-premium-program

Phone: 603-271-5218

Toll free number for the HIPP program: 1-800-852-3345, ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP

Medicaid Website:

http://www.state.nj.us/humanservices/

dmahs/clients/medicaid/

Phone: 1-800-356-1561

CHIP Premium Assistance Phone: 609-631-2392

CHIP Website: http://www.njfamilycare.org/index.html

CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website:
https://www.health.ny.gov/health_care/medicaid/

Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/

Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare

Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org

Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website:
http://healthcare.oregon.gov/Pages/index.aspx

Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website:
https://www.pa.gov/en/services/dhs/applyformedicaid-health-insurance-premium-payment-program-hipp.html

Phone: 1-800-692-7462

CHIP Website: Children's Health Insurance Program (CHIP)

(pa.gov)

CHIP Phone: 1-800-986-KIDS (5437)

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: Health Insurance Premium Payment (HIPP)

Program | Texas Health and Human Services

Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Utah's Premium Partnership for Health Insurance (UPP)

Website: https://medicaid.utah.gov/upp/

Email: upp@utah.gov

Phone: 1-888-222-2542

Adult Expansion Website:

https://medicaid.utah.gov/expansion/

Utah Medicaid Buyout Program Website:

https://medicaid.utah.gov/buyout-program/

CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid

Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access

Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website:
https://coverva.dmas.virginia.gov/learn/premium-

assistance/famis-select

https://coverva.dmas.virginia.gov/learn/premium-

assistance/health-insurance-premium-payment-hipp-programs

Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov/

Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms/

http://mywvhipp.com/

Medicaid Phone: 304-558-1700

CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm

Phone: 1-800-362-3002

WYOMING – Medicaid

Website:

https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/

Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:
U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Paperwork Reduction Act Statement

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

of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

OMB Control Number 1210-0137 (expires 1/31/2026)

Wellness Notice

BrightSpring offers voluntary wellness benefits, available on a nondiscriminatory basis to BrightSpring employees enrolled in the BrightSpring medical plan. Our program is administered according to federal laws, which permit employers to sponsor wellness programs that seek to improve employee health or prevent disease. These federal laws include, but are not limited to:

• The Americans with Disabilities Act of 1990;

• The Genetic Information Nondiscrimination Act of 2008; and

• The Health Insurance Portability and Accountability Act.

Our wellness benefits include the ability to forgo a $50 per month per tobacco user medical premium surcharge. If you do not complete the annual tobacco attestation form or you indicate that you and/or your spouse are tobacco users, you can avoid the tobacco surcharge by completing a free tobacco cessation program. Even if you don't complete the tobacco cessation program you may still be entitled to a reasonable accommodation or an alternative standard, which if approved and completed will also result in you avoiding the tobacco surcharge. To request a reasonable accommodation or an alternative standard you can contact BrightSpringBenefits@BrightSpringHealth.com. Completing the tobacco cessation program or an agreed-upon alternative will result in the full waiver of the surcharge (retroactively, back to the start of the applicable calendar year).

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. BrightSpring uses the Healthy Guidance Tobacco Cessation Program through GuidanceResources, which may aggregate information; however, GuidanceResources will never disclose any of your personal information either publicly or to BrightSpring, except as necessary to respond to a request from you for a reasonable accommodation or alternative standard, to access or process BrightSpring wellness benefits, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with wellness benefits will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to wellness benefits, and you will not be asked or required to waive the confidentiality of your health information as a condition of receiving a benefit. Anyone who receives your information for purposes of providing you wellness benefits or services will abide by the same confidentiality requirements.

In addition, all medical information obtained to administer our wellness benefits will be kept separate from your personnel records, all relevant information stored electronically will be encrypted, and no information you provide will be used in making any employment decision. BrightSpring maintains specific safeguards to protect the privacy and security of this information, in compliance with the Health Insurance Portability and Accountability Act. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide, we will notify you promptly.

BrightSpring will not discriminate against you because of the medical information you provide (if any) to

access wellness benefits and will not retaliate against you if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact BrightSpringBenefits@BrightSpringHealth.com.

General Notice of COBRA Continuation Coverage Rights

Introduction

You're getting this notice because you recently gained coverage under the BrightSpring Health Services Welfare Benefit Plan (the "Plan"). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA continuation coverage?

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

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

• Your hours of employment are reduced, or

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

• Your spouse dies;

• Your spouse's hours of employment are reduced;

• Your spouse's employment ends for any reason other than his or her gross misconduct;

• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

• You become divorced or legally separated from your spouse.

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

• The parent-employee dies;

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

• The parent-employee's employment ends for any reason other than his or her 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."

When is COBRA continuation coverage available?

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

• The end of employment or reduction of hours of employment;

• Death of the employee; or

• The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?

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

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

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

Disability extension of 18-month period of COBRA continuation coverage

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

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

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still

employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

• The month after your employment ends; or

• The month after group health plan coverage based on current employment ends.

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

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

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

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

Keep your Plan informed of address changes

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

Plan contact information

BrightSpring Benefits Support Center

844-896-0169

[1] https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.96%1 of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.12

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

1 Indexed annually.

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

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

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special

Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace

or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact BrightSpring Benefits Support Center at 844.896.0169.

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name: Res-Care, Inc. d/b/a BrightSpring Health Services

4. Employer Identification Number (EIN): 610875373

5. Employer address: 805 N. Whittington Pkwy

6. Employer phone number: 502.394.2100

7. City: Louisville

8. State: KY

9. ZIP: 40222

10. Who can we contact about employee health coverage at this job? BrightSpring Benefit Support Center

11. Phone number (if different from above): 844.896.0169

12. Email address: BrightSpringBenefits@BrightSpringHealth.com

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

•As your employer, we offer a health plan to:

☐All employees.

☒Some employees. Eligible employees are: Full Time scheduled to work 30 or more hours per week. Part-time Eligible that average 30 or more hours per week over the measurement period.

- With respect to dependents:

☒We do offer coverage. Eligible dependents are: Legally married spouse, domestic partner, dependents under the age of 26 and disabled dependents over the age of 26 who became disabled prior to attaining age 26.

☐We do not offer coverage.

The coverage your employer offers to eligible employees meets the minimum value standard, and the cost of this coverage is intended to be affordable, based on the employee wages.

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

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

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

14. Does the employer offer a health plan that meets the minimum value standard*?

☒Yes ☐No