EMPLOYEE BENEFITS ENROLLMENT GUIDE 2022

AROK
INTERIOR & EXTERIOR SYSTEMS CONTRACTOR

Disclaimer: The abbreviated outlines of benefits used throughout this document are not intended to express any legal opinion as to the nature of coverage. They are only visuals to a basic understanding of coverages and do not detail all the contract terms nor do they alter any contract conditions. Please read your contract for specific coverages, limitations, and exclusions and call us with questions.

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Introduction

This summary provides information on the employee benefits that apply to you as an employee of AROK, Inc. AROK has taken into account the particular needs of our employees and the competitive constraints of the marketplace in which AROK, Inc. operates.

Where to Find Full Benefit Summaries and Summary Plan Descriptions (SPD):
This document is intended to give you a brief outline of the benefits available to you as an employee of AROK, Inc.. There may be additional limitations and exclusions. All employees are encouraged to review the full plan summaries and SPDs that are available on Employee Navigator. A hard copy of these documents can also be requested from the Human Resources Department.

While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual Plan documents, the actual Plan documents will prevail.

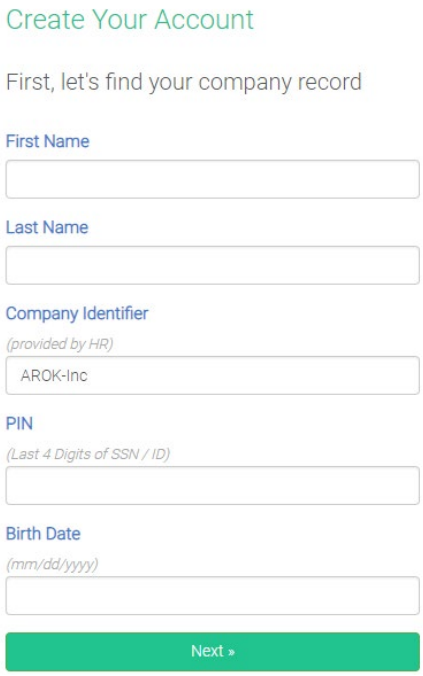
Coordination of Benefits

The medical plan coordinates benefits when you have duplicate coverage through another employer. When the Company plan is the secondary payer of benefits (for example, on claims for your dependent children), the combined total paid by both plans will not exceed the Company's normal plan benefits. This will not change what the AROK, Inc. plan pays when it is the primary plan (for example, on claims for you). You must follow your medical plan's rules to ensure appropriate coordination of benefits.

When and How to Enroll

Open Enrollment

Each year during open enrollment, you have the opportunity to elect your benefits for the upcoming year. For 2022 AROK will be utilizing an online enrollment system to enroll for benefits, www.employeenavigator.com. You must either visit this site or complete a "No Changes" form in order to enroll. The window to do so will be open from February 17, 2022 through February 24, 2022. To register for an account you will need the following information. Your Company Identifier is **AROK-INC**



The only other time you may change these benefits is when you have a qualified change in life/family status (this is because of Section 125, an IRS regulation that limits changing pre-tax benefits at any time other than during open enrollment or due to a qualified change in family status). If you wish to change your benefits, any change to your coverage must be elected within 30 days of the qualifying change in status. Plus, the changes must be consistent with the nature of the change in status. For example: if you get married, you may add a spouse or other eligible dependents to medical, vision, and dental coverage as well as elect spouse life insurance and spouse AD&D coverage, if the plans allow it. During open enrollment, all employees must log into the Employee Navigator open enrollment system and complete the enrollment process online to either elect or decline coverage for the 2021 plan year.

Note that if you enroll in MetLife Voluntary Life Plan and elect a coverage amount above the guarantee issue amount or increase your current benefit, you will need to complete the Statement of Health Form. This form is available on the Employee Navigator website. It is your responsibility to complete this form and submit it to MetLife. The Voluntary Life Insurance will not be effective until it is approved by MetLife.

Newly-Hired Employees

Newly-hired employees who work 30 hours or more are eligible for all benefits effective the first of the month following 60 days after your date of hire. It is the employee's responsibility to make all applicable enrollment and beneficiary elections within 30 days of their eligibility date. If the benefit elections are not made in this timeframe, coverage may not be available. All new hires must also log into Employee Navigator per the instructions for Open Enrollment, above, and make your elections.

Note that if you enroll in MetLife Voluntary Life Plan for an amount in excess of the Guarantee Issue Amount, you will need to complete the Statement of Health Form. It is your responsibility to complete this form and submit it to MetLife. The amount of voluntary life insurance in excess of the guarantee issue will not be effective until it is approved by MetLife.

Family Status Changes

You may change your coverage if you experience any of the following qualified changes in life/family status:

- Marriage
- Divorce
- Loss or gain of an eligible dependent
- Change in your spouse's employment
- Change in employment status (ex: From Part-Time to Full-Time) for you or your spouse
- Gain or involuntary loss of your spouse's medical coverage, or
- Change of your home address out of the medical plan service area in which you are enrolled.

IMPORTANT: Failure to enroll within 30 days of your initial eligibility for any benefit plan offering may affect you and your eligible dependents coverage at a later date.

***NOTE:** On the Health Plan when the dependent child reaches the limiting age of 26, coverage will end at the end of the month. For voluntary benefits when the dependent child reaches the limiting age of 26, coverage will end at midnight of the birthday or if the child marries coverage ends on that date.

Medical Benefits

Carrier: United Healthcare
Benefits Begin: 1st of the month following 60 days of Hire
Networks: Doctor Plan Plus and Choice Plus

MEDICAL CARRIER MEDICAL PLAN NAME	United Healthcare Dr Plan Plus $5,000 80% CHI9	United Healthcare Choice Plus 3,000 HSA 90% CHGS	United Healthcare Choice Plus $4,000 100% CHHF	United Healthcare Choice Plus $1,000 90% CHHL
Network	Doctor Plus	Choice Plus	Choice Plus	Choice Plus
GENERAL INFORMATION	IN NETWORK	IN NETWORK	IN NETWORK	IN NETWORK
Deductible - Single	$5,000	$3,000	$4,000	$1,000
Deductible - Family	$10,000	$6,000	$8,000	$2,000
Out of Pocket Max - Single	$8,550	$6,250	$5,000	$4,000
Out of Pocket Max - Family	$17,100	$12,500	$10,000	$8,000
OUTPATIENT & INPATIENT SERVICES				
Telehealth Visit	No Charge	10% after deductible	No Charge	No Charge
Primary Care Visit	No Charge	10% after deductible	$20 copay	$20 copay
Specialist Visit	$75 copay	10% after deductible	$40 copay	$40 copay
Preventive Care	No Charge	No Charge	No Charge	No Charge
Outpatient Facility	20% after deductible	10% after deductible	0% after deductible	10% after deductible
Inpatient Facility	20% after deductible	10% after deductible	0% after deductible	10% after deductible
MEDICAL EQUIPMENT & TESTS				
X-Ray & Labs	20% coinsurance	10% after deductible	$25 copay	$25 copay
Advanced Imaging	20% coinsurance	10% after deductible	$500 copay	$500 copay
EMERGENCY SERVICES				
Emergency Room Visit	$500 copay	10% after deductible	$400 copay	$400 copay
Urgent Care	No Charge	10% after deductible	$50 copay	$50 copay
PRESCRIPTION DRUG COVERAGE				
Tier 1	$5 copay	$10 copay after deductible	$10 copay	$15 copay
Tier 2	$40 copay	$35 copay after deductible	$35 copay	$35 copay
Tier 3	$105 copay	$70 copay after deductible	$70 copay	$70 copay
Tier 4	$250 copay	na	na	na

*****Amounts listed above are employee cost share**

Medical Benefit Premium

Pre-tax Premium

Premiums for the medical plans are automatically withheld pre-tax. You cannot change or revoke your election for these plans before the end of the 2023 plan year unless a Change in Status Event occurs, as defined in the AROK, Inc. Summary Plan Description.

New Network Update!

This year the Navigate network plan is being replaced by United Healthcare's new provider network option called the Doctor's Plan Plus Network! The new network does not require a Primary Care Physician for your referrals but they are free to see and help drive your healthcare. The new network is made up of mostly Banner Health providers, be sure to check out if your provider is in network or choose a new one at www.welcometouhc.com/dpaz

Here are some of the great highlights of the new plan option available in 2022-2023 for you and your family!

Lower out-of-pocket costs.

- $0 copays for PCP visits.[1]
- $0 copays for urgent care visits.[1]
- Working with a PCP may help you avoid cost surprises.

A streamlined experience.

- Easier ways to find a doctor.
- Access to a national network of providers and facilities.
- Your PCP will act as a guide through the health care system and help coordinate additional care.

Convenient access to care.

- Choose from a network of quality physicians.
- No referrals needed to see network specialists.
- Network specialty care and programs for many conditions, including cancer, heart, diabetes, behavioral health and Alzheimer's.

[1]Additional copays, deductibles or coinsurance may apply when you receive other services - such as surgery and lab work.

Go anywhere in our network.

Choosing Doctors Plan Plus means you get access to a vast network of hospitals and medical centers in your area.

Visit welcometouhc.com/dpaz for the complete network list.

Health Savings Account (HSA)

If you participate in the high-deductible health plan, you can set aside money in a Health Savings Account (HSA) before taxes are deducted to pay for eligible medical, dental and vision expenses. An HSA is similar to a flexible spending account in that you are eligible to pay for health care expenses with pre-tax dollars. There are several advantages of an HSA. For instance, money in an HSA can be invested much like 401(k) funds are invested. Unused money in an HSA account is NOT forfeited at the end of the year and is carried forward. Also, your HSA account is yours to keep which means that you can take it with you if you change jobs or retire. If you have any money remaining in your HSA after your retirement, you may withdraw the money as cash.

The maximum amount that you can contribute to a HSA in 2022 is $3,600 for individual coverage and $7,200 for family coverage. Additionally, if you are age 55 or older, you may make an additional "catch-up" contribution of $1,000.

Dental Benefits

Carrier: United Healthcare
Benefits Begin: 1st of the month following 60 Days of Hire

Consumer MaxMultiplier Options PPO

In-Network Services

	Dental PPO
General Provisions	
Deductible: Individual	$50
Deductible: Family	Up to $150
Annual Maximum Benefit	$1,500
Orthodontia Lifetime Maximum: Child	$1,000
Orthodontia Lifetime Maximum: Adult	Not Covered
Copays & Coinsurance	
Preventive Services	100% no deductible
Basic Services	100%
Major Services	50%
Orthodontia Services	50%

Waiting periods only apply to late entrants: 12 months for anything other than cleanings, exams and x-rays.

VOLUNTARY VISION

Carrier: United Healthcare
Benefits Begin: 1st of the month following 60 Days of Hire

Network: Spectera

In-Network Services

	United Healthcare Vision
Benefits	
Eye Exams	$10 copay
Materials	$25 copay
Frames	Up to $130 allowance + 30% discount off balance
Lenses	Covered according to schedule
Contact Lenses (in lieu of frames)	Up to 4 boxes or $125 allowance
Laser Eye Correction	15% if utilizing in-network surgeon
Frequency	
Exam Frequency	12 months
Lense Replacement Frequency	12 months
Frame Replacement Frequency	24 months

Basic Life and AD&D

Carrier: MetLife
Benefits Begin: 1st of the month following 60 Days of Hire

You can choose your beneficiary and update this at any time via Employee Navigator.

Employer paid benefit	Schedule of Benefits
Life and AD&D Benefit Amount	
Employee	$25,000
Waiver of Premium - Life Only	6 months
Conversion - Life Only	Included
Reduction of Benefits Schedule (both Life and AD&D)	
Age 64 or Younger	No reduction
65-69	65% of Original Benefit
70 or Older	50% of Original Benefit

Voluntary Life Insurance

Carrier: MetLife
Benefits Begin: 1st of the month following 60 Days of Hire

General Plan Information	Schedule of Benefits
Life and AD&D Benefit Amount	
Employee	$10,000 increments
Spouse	$5,000 increments
Child(ren)	$1000 / $2000 / $4000 / $5000 / $10,000
Guarantee Issue Amount *(max. amount without completing health questionnaire)*	
Employee	$100,000
Spouse	$25,000
Child(ren)	$10,000
Overall Maximum	
Employee	5x Annual salary up to $500,000
Spouse	50% of employee benefit up to $100,000
Child(ren)	$10,000

Monthly Cost for Each $1,000 of Employee, Spouse*, and Child Life Insurance Coverage
*Spouse rates based on Employee age

Age	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70 +
Employee & Spouse Life/AD&D	$0.121	$0.123	$0.142	$0.197	$0.292	$0.447	$0.685	$1.027	$1.63	$3.05
Children Life/AD&D	$0.200 per $1,000 (maximum coverage is $10,000)									

Calculation Example: *Multiply the monthly premium by 12 and divide by 24 pay periods for per pay premium*

Amount of Coverage		*Divided by 1,000*				*Times Rate Above*		*Equals total monthly cost*
$50,000	/	*1,000*	=	*50*	X	*$0.123*	=	*$6.15*

Your Amount of Coverage		*Divided by 1,000*				*Times Your Rate from Above*		*Equals your total <u>monthly</u> cost*
_____	/	1,000	=	_____	X	_____	=	_____

CONTACT INFORMATION

MEDICAL United Healthcare	United Healthcare	866-414-1959 www.myuhc.com
DENTAL United Healthcare	United Healthcare	866-414-1959 www.myuhc.com
VOLUNTARY VISION United Healthcare	United Healthcare	866-414-1959 www.myuhc.com
LIFE AND AD&D MetLife Group #5760353	MetLife	800-275-4638 www.metlife.com
BENEFITS QUESTIONS The Clear Group	The Clear Group Lindsey Lindhorst	(480) 462-0147 llindhorst@getclearconsulting.com

REGULATORY NOTICES

Certain State and Federal Regulations require employers to provide disclosures of these regulations to all employees. The remainder of this document provides you with the required disclosures related to our employee benefits plan. If you have any questions or need further assistance please contact your Plan Administrator as follows:

AROK, Inc.
2819 West Grovers Avenue
Phoenix, Arizona 85053
602-997-1492

WHERE TO FIND FULL BENEFIT SUMMARIES AND SUMMARY PLAN DESCRIPTIONS (SPD):
This document is intended to give you a brief outline of the benefits available to you as an employee of AROk, Inc. There may be additional limitations and exclusions. All employees are encouraged to review the full benefit summaries, Summary of Benefits and Coverage (SBC) and Summary Plan Descriptions (SPDs). A printed copy of these documents can be requested from the Human Resources Department or viewed in the Knowledge Coop.

While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual Plan documents, the actual Plan documents will prevail.

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

If you do not timely or properly complete the enrollment process, you and your Eligible Dependents generally will not be covered under the applicable Plan, except as described below. Also, if you fail to specifically enroll your Eligible Dependents on the enrollment form, your Eligible Dependents will not be covered under the applicable Plan, except as otherwise provided below.

Loss of Other Coverage
If you decline enrollment because you or your dependent had other group health plan coverage, either through COBRA or otherwise, you may enroll yourself and Eligible Dependents in the Medical Program within **30 days** of the loss of that coverage. Your enrollment will become effective on the date you enroll in the Medical Program. For this purpose, "loss of coverage" will occur if the other group health plan coverage terminates as a result of: (i) termination of employer contributions for the other coverage; (ii) exhaustion of the maximum COBRA period; (iii) legal separation or divorce; (iv) death; (v) termination of employment; vi) reduction in hours of employment; or (vii) failure to elect COBRA coverage.

However, a loss of coverage will not be deemed to occur if the other coverage terminates due to a failure to pay premiums or termination for cause. At the time you enroll in the Employer's Plan, you must provide a written statement from the administrator of the other medical plan that you no longer have that 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 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. Your enrollment will become effective on the date of marriage, birth, adoption 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 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 Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

Other Circumstances
You may enroll an Eligible Dependent child for whom you are required to provide medical coverage pursuant to a Qualified Medical Child Support Order (as defined under ERISA Section 609). This enrollment of an Eligible Dependent will become effective as of the Plan Administrator's qualification and acceptance of the Qualified Medical Child Support Order.

You are eligible to enroll yourself and your Eligible Dependents in the Plan under any other special circumstances permitted under the applicable Benefits Guide (and subject to the Cafeteria Plan rules outlined in Section 125 of the Internal Revenue Code).

NOTE: You will not be allowed to enroll yourself and/or Eligible Dependents for coverage in the Plan for a Plan Year unless you timely and affirmatively complete the enrollment process by the deadlines set forth above (i.e. within 30 days for loss of coverage or new dependents; within 60 days for Medicaid or CHIP circumstances; within 30 days of receipt of this notice for a dependent under the age of 26; or within the deadline established by the Plan Administrator for Open Enrollment Period).

Should you have any questions regarding this information or require additional details, please contact the Plan Administrator at the address or phone number listed at the beginning of this document.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE (JANET'S LAW)

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary may elect breast reconstruction in connection with a mastectomy. Group health plans and insurers offering mastectomy coverage must also provide coverage for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to pro- duce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas

These services are payable to a patient who is receiving benefits in connection with a mastectomy and elects reconstruction. The physician and patient determine the manner in which these services are performed. The plan may apply deductibles and copayments consistent with other coverage within the plan. This notice serves as the official annual notice and disclosure of that the fact that the company's health and welfare plan has been designed to comply with this law.

MICHELLE'S LAW NOTICE

On Thursday, October 9, 2008, President Bush signed into law H.R. 2851, known as Michelle's Law. This law requires employer health plans to continue coverage for employees' dependent children who are college students and need a medically necessary leave of absence. This law applies to both fully insured and self-insured medical plans. The dependent child's change in college enrollment must meet the following requirements:

- The dependent is suffering from a serious illness or injury.
- The leave is medically necessary.
- The dependent loses student status for purposes of coverage under the terms of the plan or coverage.

Coverage for the dependent child must remain in force until the earlier of:

- One year after the medically necessary leave of absence began.
- The date the coverage would otherwise terminate under the terms of the plan.

A written certification by the treating physician is required. The certification must state that the dependent child is suffering from a serious illness or injury and that the leave is medically necessary. Provisions under this law become effective for plan years beginning on or after October 9, 2009.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT NOTICE

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

FAMILY MEDICAL LEAVE ACT/MILITARY FAMILY LEAVE

Federal law requires that Eligible Employees be provided a continuation period in accordance with the provisions of the Federal Family and Medical Leave Act (FMLA). The details of this law are provided in your Summary Plan Description (SPD). If you would like more information regarding FMLA, contact your plan administrator at the address and phone number listed at the beginning of this document.

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

The right to COBRA continuation coverage was created by 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.

If you are enrolling in AROK's plan you will receive an Initial Notice of your COBRA rights from Human Resources.

MEDICARE NOTICE

You must notify AROK, Inc. when you or your dependents become Medicare eligible. AROK, Inc. is required to contact the insurer to inform them of your Medicare status. Federal law determines whether Medicare or the group health plan is the primary payer. You must also notify Medicare directly that you have group health insurance coverage. Privacy laws prohibit Medicare from discussing coverage with anyone other than the Medicare beneficiary or their legal guardian.

The toll free number to Medicare Coordination of Benefits is 1-800-999-1118. If you have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices in your prescription drug plan. Please see the complete Medicare Part D Non-Creditable Coverage Notice below.

Should you have any questions regarding this information or require additional details please contact the Plan Administrator at the address or phone listed at the beginning of this document.

IMPORTANT INFORMATION ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please note that the following notice only applies to individuals who are eligible for Medicare. Medicare eligible individuals may include employees, spouses or dependent children who are Medicare eligible for one of the following reasons.

- Due to the attainment of age 65
- Due to certain disabilities as determined by the Social Security Administration
- Due to End Stage Renal Disease (ESRD)

If you are covered by 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 AROK, Inc. 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. AROK, Inc. has determined that the prescription drug coverage offered by their carrier's Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. If 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 through 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 coverage will not be affected. Your current coverage pays for other health expenses in addition to prescription drugs. The prescription drug coverage is part of the Group Health Plan and cannot be separated from the medical coverage. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits. You have the option to waive the coverage provided under the Group Health plan due to your eligibility for Medicare. If you decide to waive coverage under the Group Health Plan due to your Medicare eligibility, you will be entitled to re-enroll in the plan during the next open enrollment period.

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 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 your HR Representative. 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 your company 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" hand-book. 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, visit Social Security at www.socialsecurity.gov, or call 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 require to pay a higher premium (penalty).

Date:	January 1, 2022
Name of Entity/Sender:	AROK, Inc.
Contact:	Human Resources
Address:	2819 West Grovers Avenue Phoenix, Arizona 85053
Phone Number:	602-997-1492

NOTICE OF PRIVACY PRACTICES

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

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by the AROK, Inc. Benefit Plan (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on May 1, 2015.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. AROK, Inc. requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

Continues…

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the

protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of AROK, Inc. for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures. Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below. If you have any questions or complaints, please contact:

Controller
AROK, Inc., 2819 West Grovers Avenue, Phoenix, Arizona 85053
Phone: (602) 997-1492 | Email: acannon@arok.com

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

NEW HEALTH INSURANCE MARKETPLACE COVERAGE

Options and Your Health Coverage
There is an additional way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from November 1 through December 15 of the previous year. After that date, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86 percent of your household income for 2020, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.
(An employer-sponsored 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.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact your human resources department.

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**FLORIDA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711	Website: http://dhs.iowa.gov/hawk-i Phone: 1-800-257-8563
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://chfs.ky.gov Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

MAINE – Medicaid	**NORTH CAROLINA – Medicaid**

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282	

To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

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

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

PAPERWORK REDUCTION ACT STATEMENT

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 12/31/2020)