Virtual Radiologic Services (VRS)

2025 Benefit Enrollment

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 24 where Notice of Creditable Coverage begins for more details.

Your 2025 Benefits

Virtual Radiologic Service (VRS) believes in making a positive impact not only within our industry but also with our radiologists. We take pride in offering comprehensive benefits in a vast array of plans that contribute to the present and future well-being of our radiologists and their families. Some benefits are provided at no cost, while others require a cost share between radiologists and VRS. Radiologists may also select voluntary plans and pay for these benefits through convenient payroll deductions. While you have many options to select from, getting the best value depends on understanding and using your benefits wisely. When deciding which plans are best for you, take into account:

- The premium cost (your monthly payroll deductions);
- Your out-of-pocket cost when you receive care (copays, deductibles, coinsurance);
- The type of healthcare services you expect to use; and
- Other coverage you might have - for example, through your spouse's employer.

We hope you find this guide useful as you consider your options. The benefit programs are just one of the many ways VRS helps our Radiologists take care of themselves and their dependents. Thank you for being part of the VRS team, and for helping to make a difference to the patients we serve!

This Benefit Guide provides a summary of your benefit options and costs to help you make informed choices. For additional information on the enrollment process and specific details of your plan, please contact HR.

WHAT'S NEW FOR 2025

1. The IRS has increased the HSA contribution limits for 2025 to $4,300 individual and $8,550 family, with $1,000 catch-up for those age 55 or older.

2. For 2025, the IRS has set the Healthcare and Limited Purpose FSA limits to $3,300, and they have increased the amount you can carry over from 2025 into 2026 to $660.

3. The IRS will no longer allow no-cost telehealth (VirtuWell, Doctor on Demand, and Teladoc) before you have met your deductible on the Gold or Silver High Deductible Health Plans. See pages 6 and 7 for telehealth coverage information.

4. VSP has increased the premium for the voluntary employee-paid vision plan.

5. Medical premiums are increasing for 2025.

Benefit Basics

If you are a full-time VRS radiologist who works an average of 20 hours or more a week, you are eligible to enroll in the benefits described in this Benefit Guide the first of the month coinciding with or following your date of hire. You must enroll in the medical, dental, vision and dependent life insurance plans in order to cover your eligible dependents on these plans, including:

- Your legal spouse
- Natural, adopted or step-children up to age 26 for medical, dental, and vision insurance
- Children under your legal guardianship
- Any child who is named in a Qualified Medical Support Order (QMCSO) as defined under federal law
- Disabled children who have reached the maximum age and who are (or become) physically or mentally incapable of self-support (medical certification required)

This Benefit Guide provides a summary of your benefit options and associated costs. For additional information on the enrollment process and specific details of your plan, please contact Human Resources.

Qualified Life Events

Generally, you may only change your benefit elections during the annual enrollment period. However, you may change your benefit elections during the year if you experience a qualified life event, including:

- Marriage
- Divorce or legal separation
- Birth of your child
- Death of your spouse, or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of Radiologist, spouse or dependent child
- Qualification by the Plan Administrator of a child support order for medical coverage
- Entitlement to Medicare or Medicaid
- Certain other events explicitly allowed by the IRS (See Human Resources if you think you might qualify.)

You must notify Human Resources within 31 days of the qualified life event. Depending on the type of event, you may need to provide proof of the event. If you do not contact Human Resources within 31 days of the qualified event, you will have to wait until the next annual enrollment period to make changes (unless you experience another qualified life event).

Medical Plan Tips

VRS offers healthcare plans from HealthPartners which is a part of the Cigna nationwide network to help you and your family members live healthier lives. You have three plan options for healthcare coverage, including:

- Platinum PPO
- Gold High Deductible Health Plan
- Silver High Deductible Health Plan

VRS's group medical plans are designed to help Radiologists and their families obtain quality healthcare and provide financial protection when large unexpected medical bills are incurred.

Regardless of which medical plan option you choose, you contribute to the cost of your coverage through pre-tax payroll deductions. By paying on a pre-tax basis, your actual cost for coverage is lower, because the contributions you pay toward your coverage are not subject to federal income tax withholding or Social Security taxes.

Please review each option and consider how it will benefit you and your family members.

Platinum PPO

This plan is a traditional Preferred Provider Organization (PPO) plan that is a good choice for Radiologists willing to pay higher payroll contributions in exchange for lower deductibles. With a traditional PPO plan, you can choose any in-network provider but if you "step outside the network," you may be required to pay the provider directly then file a claim with the carrier for an out-of-network reimbursement, and you may be balance-billed by the provider. Your annual out-of-network maximum includes all deductible, coinsurance and flat dollar copayments.

Wellness Tip

Because VRS believes in the importance of preventive care and wellness measures, the medical plans cover many adult and child wellness tests and screenings at 100% when you receive services from a participating in-network HealthPartners provider.

Making the most of your preventive health coverage means there is:

- No cost to you!
- No plan deductible to meet or copay to pay, regardless of the plan you choose!

Your doctor will determine the tests that are right for you based on your age, gender and family history. 100% coverage is provided for those services meeting standard preventive care guidelines.

High Deductible Health Plans (HDHP)

The high-deductible health plans (HDHP) are health plans with lower payroll contributions in exchange for higher deductibles than the Platinum PPO health plan. The deductible is the amount of money you must spend before medical and prescription drug benefits are paid. The annual out-of-pocket limit is the maximum amount of money you will pay before medical and prescription drug services are covered at 100% for the remainder of the plan year. The annual out-of-pocket maximum includes all deductible and coinsurance payments. You have two HDHP plans to choose from, the Gold HDHP and Silver HDHP plan. Both HDHPs are HSA qualified plans, so you can contribute to a tax-advantaged Health Savings Account.

VirtuWell

It's Your 24/7 Online Clinic

Sinus infection? Pinkeye? Now there is a way to quickly and conveniently get care for these and over 50 common conditions. It's called VirtuWell. Designed by physicians, VirtuWell is an online clinic that treats everyday illnesses so consumers can get better faster.

Quick, Convenient, Safe

1. A VirtuWell visit starts with a quick online interview that checks your medical history and makes sure the problem isn't serious. Login to www.virtuwell.com
2. Next, a certified nurse practitioner will review the case and write a personalized treatment plan. An email or text is sent the moment the plan is ready.
3. If a prescription is needed, VirtuWell will send it to the pharmacy of choice
4. If you need to speak with a nurse practitioner about your plan, they're available 24/7.

It's Part of Your Health Benefits

Telemedicine is part of your health benefits which are administered by HealthPartners.

Here are some of the conditions treated at VirtuWell

- Allergies
- Bladder infection
- Bronchitis
- Cough/cold
- Diarrhea
- Fever
- Pink Eye
- Rash
- Seasonal Flu
- Sinus problems
- Sore throat
- Stomach ache

Virtuwell is licensed to offer diagnosis and treatment in the following states.

- Arizona
- California
- Colorado
- Connecticut
- Iowa
- Michigan
- Minnesota
- New York
- North Dakota
- Pennsylvania
- South Dakota
- Virginia
- Wisconsin

Use VirtuWell when:

- Your doctor is not available
- You become ill while traveling
- You are considering visiting a hospital emergency room for a non-emergency health condition

VirtuWell		
Your Cost		
	Before Deductible	After Deductible
Platinum	$0	$0
Gold	Varies*	$0
Silver	Varies*	$0

* Varies by type of service and by provider, though rates are typically lower than in-person visits.

Teladoc & Doctor on Demand

More Virtual Care Options

For those who reside in ANY state, your plan also includes virtual providers **Teladoc** and **Doctor on Demand.**

Like VirtuWell, Teladoc and Doctor on Demand are available 24/7 for non-emergency minor acute conditions. Teladoc and Doctor on Demand can also provide Primary Care for adults and children – check-ups and ongoing wellness needs and referrals.

- Allergies
- Bladder infection
- Bronchitis
- Cough/cold
- Diarrhea
- Fever
- Pink Eye
- Rash
- Seasonal Flu
- Sinus problems
- Sore throat
- Stomach ache

Teledoc / Doctor on Demand for Minor Acute Conditions		
	Your Cost	
	Before Deductible	After Deductible
Platinum	$0	$0
Gold	Varies*	$0
Silver	Varies*	$0

* Varies by type of service and by provider, though rates are typically lower than in-person visits.

Mental Health and Dermatology visits are also available virtually. These types of visits will be billed like regular primary care and specialist office visits.

Your Medical Plans

	HealthPartners Platinum PPO	
	In-Network	Out-of-Network
Annual Deductible	$1,500 Individual $4,500 Family	$3,000 Individual $9,000 Family
Out-of-Pocket Maximum (includes deductible)	$4,500 Individual $9,000 Family	$9,000 Individual $27,000 Family
Lifetime Maximum	Unlimited	Unlimited
Preventive Care	Covered 100%	50% after deductible
Primary Physician Office Visit	$30	50% after deductible
Specialist Office Visit Open Access – no referrals required	$60	50% after deductible
Inpatient Hospital Services	20% after deductible	50% after deductible
Outpatient Hospital Services	20% after deductible	50% after deductible
Diagnostic Lab Facility	No charge	50% after deductible
Diagnostic X-ray Facility	No charge	50% after deductible
Major Service – PET Scans, MRI, CT Scans	20%, not subject to deductible	50% after deductible
Urgent Care	$50 copay, not subject to deductible	50% after deductible
Emergency Room Care	$200, then 20% coinsurance	$200, then 20% coinsurance
Prescription (Rx) Drug Plan		
Retail Drugs (30-day supply), not subject to deductible		
Formulary Generic	20% ($15 max)	Not covered
Formulary Brand	25% ($75 max)	
Non-Formulary Drugs	30% ($125 max)	
Specialty Medication	30% ($250 max)	
Mail Order Drugs (90-day supply), not subject to deductible	2x retail	Not covered

Radiologist Monthly Contributions	
Coverage Tier	
Radiologist	$433.15
Radiologist + 1	$954.75
Radiologist + Family	$1,431.88

Your Medical Plans

	HealthPartners Gold HDHP	
	In-Network	Out-of-Network
Annual Deductible	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family
Out-of-Pocket Maximum (includes deductible)	$5,000 Individual $10,000 Family	$10,000 Individual $20,000 Family
Lifetime Maximum	Unlimited	Unlimited
Preventive Care	Covered 100%	50% after deductible
Primary Physician Office Visit	20% after deductible	50% after deductible
Specialist Office Visit Open Access – no referrals required	20% after deductible	50% after deductible
Inpatient Hospital Services	20% after deductible	50% after deductible
Outpatient Hospital Services	20% after deductible	50% after deductible
Diagnostic Lab Facility	20% after deductible	50% after deductible
Diagnostic X-ray Facility	20% after deductible	50% after deductible
Major Service – PET Scans, MRI, CT Scans	20% after deductible	50% after deductible
Urgent Care	20% after deductible	50% after deductible
Emergency Room Care	20% after deductible	50% after deductible
Prescription (Rx) Drug Plan		
Retail Drugs (30-day supply)		
Formulary Generic	20% ($15 max)	Not covered
Formulary Brand	25% ($75 max)	
Non-Formulary Drugs	30% ($125 max)	
Specialty Medication	30% ($250 max)	
Mail Order Drugs (90-day supply)	2x retail	Not covered

Radiologist Monthly Contributions	
Coverage Tier	
Radiologist	$276.76
Radiologist + 1	$635.24
Radiologist + Family	$944.81

Your Medical Plans

	HealthPartners Silver HDHP	
	In-Network	Out-of-Network
Annual Deductible	$3,500 Individual $7,000 Family	$7,000 Individual $14,000 Family
Out-of-Pocket Maximum (includes deductible)	$6,900 Individual $13,800 Family	$14,000 Individual $28,000 Family
Lifetime Maximum	Unlimited	Unlimited
Preventive Care	Covered 100%	50% after deductible
Primary Physician Office Visit	20% after deductible	50% after deductible
Specialist Office Visit Open Access – no referrals required	20% after deductible	50% after deductible
Inpatient Hospital Services	20% after deductible	50% after deductible
Outpatient Hospital Services	20% after deductible	50% after deductible
Diagnostic Lab Facility	20% after deductible	50% after deductible
Diagnostic X-ray Facility	20% after deductible	50% after deductible
Major Service – PET Scans, MRI, CT Scans	20% after deductible	50% after deductible
Urgent Care	20% after deductible	50% after deductible
Emergency Room Care	20% after deductible	50% after deductible
Prescription (Rx) Drug Plan		
Retail Drugs (30-day supply)		
Formulary Generic	20% ($15 max)	Not covered
Formulary Brand	25% ($75 max)	
Non-Formulary Drugs	30% ($125 max)	
Specialty Medication	30% ($250 max)	
Mail Order Drugs (90-day supply)	2x retail	Not covered

Radiologist Monthly Contributions	
Coverage Tier	
Radiologist	$176.20
Radiologist + 1	$429.69
Radiologist + Family	$629.77

Health Savings Account (HSA)

When you enroll in one of the Gold or Silver HSA qualified plans, you can choose to add additional funds to your Health Savings Account (HSA). The money you contribute to the Health Savings Account (HSA) is deducted from your paycheck on a pre-tax basis. You can use money in the account to pay for eligible healthcare expenses, including medical, dental, vision and other qualified expenses for you and your dependents.

Besides paying your healthcare expenses, an HSA has other advantages you will want to consider:

- Reduces your taxable income. You pay no federal taxes on the money you put into your HSA so you keep more of your paycheck.
- The money always belongs to you. Any money you put into an HSA earns interest depending on the investments you choose, and your balance. All the interest earned is tax-free, too.
- You control the money. You decide how to invest the funds after your account balance reaches $1,000.
- You can save the money for future needs. Even if you don't use a lot of healthcare services now, your HSA funds will be there if you need them in the future – even after retirement. Since it's your personal health savings account if you never need the money, it goes to your heirs.

How much can I contribute to an HSA? The maximum amount you and anyone else can contribute to your HSA in any year is the amount established by the IRS. The 2025 IRS amounts are $4,300 for Individual and $8,550 for Family.

When can I make "catch-up" contributions to an HSA? If you are 55 or older, or turning 55 during the calendar year, you can make additional "catch-up" contributions to your HDHP. The "catch-up" contribution is $1,000.

What qualifies as an HSA expense? Generally all plan allowed services, equipment and medication through your health, dental and vision qualify. Some IRS-approved expenses are: diabetic supplies, eye exams, eyeglasses, contact lenses and solution, hearing aids, orthodontia, dental cleanings and fillings, physical therapy, speech therapy and chiropractic expenses. See IRS Publication 502 for details. Be sure to save all receipts and prescriptions for your records.

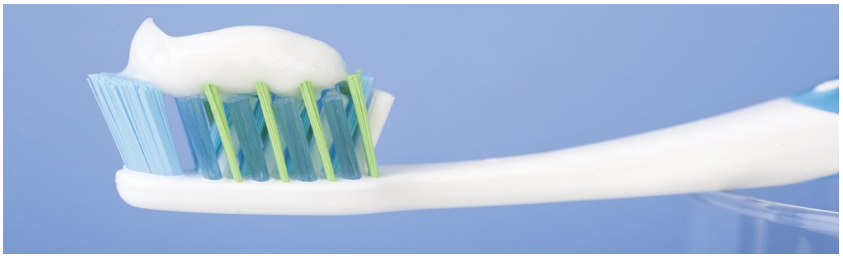
Your Dental Plan

PPO Plan – Cigna		
	In-Network Only	Out-of-Network*
Annual Deductible	$50 Individual $150 Family	$50 Individual $150 Family
Annual Benefit Maximum (per person)	$1,500	$1,500
Preventive Oral Examinations Prophylaxis/Cleaning	100%	80%
Basic Minor Restorations (Fillings) X-Rays Endodontic (Root Canal) Periodontics	80% after deductible	70% after deductible
Major Crowns Bridges Dentures	50% after deductible	40% after deductible
Orthodontia (Adult and Children)	50%; $1,500 Lifetime Maximum	
Radiologist Monthly Contribution		
Radiologist	$29.00	
Radiologist + Spouse	$59.00	
Radiologist + Child(ren)	$54.00	
Radiologist + Family	$92.00	

* Texas residents: per state law, your out of network coverage percentages are same as in-network.

How to Find a CIGNA In-Network Dental Provider

- Go to **Cigna.com**, click on “Find a Doctor” at the top of the screen.
- Then, under “How are you covered?” choose “Employer or School” option.
- Enter search location – city, state or zip code.
- Select Doctor by Type > Select from Doctor Types.
- Continue as guest.
- Select the Dental drop down box under “IF YOU ARE LOOKING FOR A CIGNA PLAN” and choose “Cigna DPPO Advantage/Cigna DPPO.” Then press “Choose.”
- You’ll be back on the “Find Providers” page with the correct dental plan selected. If you want to narrow your search, you can also type in key words, like dentist name, specialty type or office name. Then, click “Search.”
- From the Search Results page, you can further refine your search results – by distance, network, specialty, or years in practice.
- Click on a dentist’s name for more facts, such as multiple location listings with map.



Vision Plan

VRS offers a vision plan direct through VSP which covers eye exams, prescription lenses and frames, or contact lenses for you and your eligible family members. You may choose to use in or out-of-network providers. Although you may select any licensed provider, you receive the highest level of benefits when you see an in-network provider.

Vision Plan Highlights - VSP		
	In-Network Only	Out-of-Network
Well Vision Exam	$10 copay	Plan pays up to $45
Frequency Exam Lenses Frames	Every Calendar Year Every Calendar Year Every Other Calendar Year	
Frames	$120 allowance ($140 for featured frame brands or $65 at Walmart, Sam's, or Costco); 20% savings on the amount over your allowance	Plan pays up to $70
Lenses Single Vision Lenses Bifocal Lenses Trifocal Lenses	Plan pays 100% after $20 member copay	Plan pays up to: $30 $50 $65
Medically Necessary Contact Lenses	Covered in full	Plan pays up to $210
Elective Contact Lenses in Lieu of Glasses	$120 allowance	Plan pays up to $105
Employee Monthly Contributions		
Radiologist	$5.11	
Radiologist + Spouse	$10.20	
Radiologist + Child(ren)	$10.92	
Radiologist + Family	$17.46	

Flexible Spending Accounts

Administered by Wex

A Flexible Spending Account (FSA) is a program that helps you pay for healthcare and dependent care costs using tax free dollars. Each pay period, you decide how much money you would like to contribute to one or both accounts. Your contribution is deducted from your paycheck on a pretax basis and is put into the Healthcare FSA, the Dependent Care FSA, or both. When you incur expenses, you can access the funds in your account to pay for eligible healthcare or dependent care expenses.

This chart shows the 2025 eligible expenses for each FSA; how much you can contribute to each FSA each year, and how you benefit by using an FSA.

Eligible Expenses	Annual Contribution Limits	Spending Deadlines
Healthcare FSA Most medical, dental and vision care expenses that are not covered by your health plan (such as copayments, coinsurance, deductibles, eyeglasses and doctor prescribed over the counter medications). Those enrolled in the HDHP are not eligible.	$3,300 per year	Unspent amounts exceeding $660 at the end of the plan year are forfeited. Up to $660 may be carried over for use through the end of 2026.
Dependent Care FSA Dependent care expenses (such as day care, after school programs or elder care programs) so you and your spouse can work or attend school full-time.	$5,000 per year ($2,500 if married and filling separate tax returns)	All unspent funds remaining in your account at the end of the year are forfeited.
Limited Purpose FSA Designed to complement Health Savings Account (HSA). For those enrolled in a HDHP, this account allows for reimbursement of eligible dental and vision expenses.	$3,300 per year	Unspent amounts exceeding $660 at the end of the plan year are forfeited. Up to $660 may be carried over for use through the end of 2026.

Example

Here's a look at how much you can save when you use an FSA to pay for your healthcare FSA, Dependent Care FSA and Limited Purpose FSA expenses.

Example of Annual Savings*	With FSA	Without FSA
Annual taxable Income	$50,000	$50,000
Pre-tax money deposited into an FSA	($3,300)	$0
Remaining taxable income	$46,700	$50,000
Minus Average Federal and Social Security taxes	($10,578)	($11,325)
Take-home pay spent on FSA eligible expenses	$0	($3,300)
Remaining take-home pay	$36,122	$35,375
Annual Savings	$747	No savings

*This example is intended to demonstrate a typical tax savings based on 15 percent federal and 7.65 percent FICA taxes. Actual savings will vary based on your tax situation.

Life Insurance Coverage

Life and Accidental Death & Dismemberment (AD&D) Insurance

Insured by Unum

Life insurance protects your family or other beneficiaries in the event of your death while you are still actively employed at VRS. Your coverage amount will be paid to the beneficiary of your choice. VRS provides eligible physicians with coverage of one times your annual earnings, up to a maximum of $375,000, in group life insurance with Unum. Each year in January, VRS will re-assess your Base Life and AD&D coverage level and that amount will remain in effect for the calendar year. If your death is due to a covered accident or injury, your beneficiary will receive an additional amount through Accidental Death and Dismemberment (AD&D) coverage. AD&D coverage is equal to your life insurance coverage amount. AD&D benefits are also payable if you lose a limb, or have a loss of speech, hearing, or eyesight because of a covered accident (either on or off the job) and the loss occurs within one year of the covered accident. The payable amount of your AD&D benefit depends on the type of loss. In the event of death due to an accident, your beneficiary may receive both your life and AD&D benefits.

Voluntary Term Life – Radiologist, Spouse and Child(ren)

Insured by Unum

Eligible physicians may purchase Voluntary Life and AD&D insurance for themselves and their families through post-tax payroll deductions. If you purchase Voluntary Life insurance when you are first eligible, you can obtain a guarantee issue up to $130,000 for you and $50,000 for your spouse. Radiologists applying for amount over $130,000 (radiologist) and $50,000 (spouse) will need to complete an Evidence of insurability (EOI) form.

Voluntary Life Coverage Option:

- Radiologist: $10,000 to the lesser of 5x salary or $500,000
- Spouse: $5,000 increments, not to exceed 100% of Radiologist election or $500,000
- Child(ren): $5,000 increments up to $25,000

Voluntary AD&D Coverage Option:

- Radiologist: $10,000 to the lesser of 5x salary or $500,000
- Spouse: $5,000 increments, not to exceed 100% of Radiologist election or $500,000
- Child(ren): $5,000 increments up to $25,000

Voluntary AD&D	
Monthly Contributions per $1,000 of Coverage	
Radiologist, Spouse & Children	$0.022

Voluntary Life	
Monthly Contributions per $1,000 of Coverage	
Your Age	Radiologist & Spouse
Age 15-24	$0.050
Age 25-29	$0.060
Age 30-34	$0.080
Age 35-39	$0.104
Age 40-44	$0.156
Age 45-49	$0.234
Age 50-54	$0.416
Age 55-59	$0.780
Age 60-64	$1.170
Age 65-69	$1.950
Age 70-74	$3.510
75+	$12.363
Dependent Child	$0.18

Disability Insurance Coverage

Short-Term Disability and Long-Term Disability

Insured by Unum

At some point during your career, there may be a time when you are unable to work due to a serious illness or injury. Physicians are considered disabled if you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; OR you have a 20% or more loss in weekly earnings due to the same sickness or injury. After 36 months of payments, you are disabled when Unum determines that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

Earnings for purpose of these benefits is calculated using the following formula:

Additional Benefits

Employed Radiologists	Unum Earnings Definition
Radiologists reading 6+ months at vRad	The greater of your current year or prior year actual read rate x contracted WU rate x hours*
Radiologists reading <6 months at vRad	6.58 WU x WU rate x hours
This calculation and benefit does not include income received from sources other than Virtual Radiologic Services (VRS). *Contract committed hours	

Short-Term Disability Benefit	When Benefits Begin	How Long Benefits Last
VRS-paid: 60% of annual earnings, up to $2,000 per week	After your doctor certifies your disability, and you have completed the 14-day elimination period, as well as receiving Unum's approval	up to 11 weeks from the date of disability
Long-Term Disability Benefit	**When Benefits Begin**	**How Long Benefits Last**
VRS-paid: 60% of earnings, up to $10,000 per month	After your doctor certifies your disability, and you have completed the 90-day elimination period, as well as receiving Unum's approval	Generally, as long as you remain disabled under the terms of the contract; subject to maximum benefit duration period; refer to the Unum's Certificate of Coverage Individual Disability Benefit When Benefits Begin How Long Benefits
Individual Disability Benefit	**When Benefits Begin**	**How Long Benefits Last**
Radiologist-paid: 75% of monthly insurable income less Group LTD up to $6,000. Reduced: 50% of maximum	After your doctor certifies your disability, and you have completed the 90-day elimination period, as well as receiving Unum's approval	up to age 67

Disability Insurance Coverage

- 24-Hour Emergency Travel Assistance – Through your Group Life and AD&D coverage with Unum, you automatically receive emergency travel assistance services provided by Assist America. Whenever you travel 100 miles or more from home — to another country or just another city — be sure to pack your worldwide emergency travel assistance phone number! Just one phone call connects you and your family to medical and other important services 24 hours a day. To reach Assist America you can call 800.872.1414 (Within the US) or +609.986.1234 (Outside the US).

- Employee Assistance Plan – Through your Group Life and AD&D coverage with Unum, you also automatically receive Employee Assistance Program (EAP) benefits. Call for confidential access to a Licensed Professional Counselor who can help you. You can also reach out to a specialist for help with balancing work and life issues.

  Help is easy to access:

  - Online/phone support: Unlimited, confidential, 24/7.
  - In-person: You can get up to 5 visits available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

  Toll-free 24/7 access:

  - 800.854.1446 (multi-lingual)
  - www.Unum.com/lifebalance

Voluntary Supplemental Health Coverage

Voluntary Accident

Insured by Unum

Accident Insurance provides a lump-sum cash benefit for injuries you or an insured family member sustain as a result of an accident. This benefit can be used to pay out-of-pocket medical expenses, help supplement your daily living expenses and unpaid time off work. Below are some examples of reimbursed services and monthly costs.

Voluntary Accident			
Service	Paid	Service	Paid
Emergency Room	$200	Concussion	$200
Medical Appliance	$150	Lacerations	Up to $600
Physician Office Visit	$75	Dental Injury	$350 Crown; $115 Extraction
Ground Ambulance	$150	Hospital Confinement	$300/day
Air Ambulance	$750	Physical Therapy	$35 session, up to 15 sessions
Hospital Admission	$1,000	ICU Confinement	$600/day
Coma	$10,000	Organized Sport	Extra 10%

Voluntary Accident	
Coverage Tier	Radiologist Monthly Cost
Radiologist	$8.33
Radiologist + Spouse	$14.40
Radiologist + Child(ren)	$17.89
Radiologist + Family	$23.96

Voluntary Critical Illness

Insured by Unum

Voluntary Critical Illness Insurance provides a fixed, lump-sum benefit upon diagnosis of a critical illness, which can include heart attack, stroke, and more. These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and child care.

- Radiologist: Choose from a minimum of $5,000 to a maximum of $30,000 in $5,000 increments
- Spouse: Can purchase 100% of Radiologist amount
- Dependent Child(ren): 50% of Radiologist amount at no extra cost

Example Condition	% Paid
Invasive Cancer	100%
Non-Invasive Cancer	25%
Skin Cancer	$500
Major Coronary Artery Disease	50%
Heart Attack	100%
Stroke	100%
Major Organ Failure	100%
MS	100%
Coma	100%

Rates based on age / amount elected. Please reach out to your Human Resources team for updated rate information.

Voluntary Supplemental Health Coverage

Voluntary Hospital Indemnity

Insured by Unum

You don't want to be caught unprepared in a medical emergency and have to rely on your savings to cover the extra expenses you may face that your health plan may not cover such as deductibles, copays, and other out-of-pocket expenses. Hospital Indemnity provides payment directly to you if you experience hospital related services such as hospital admission or confinement, even for planned surgery and maternity stays.

Voluntary Hospital Indemnity Benefits	
Hospitalization Benefits	
Hospital Admission	$1,000 max of 1 per year
Daily Hospital Confinement	$100 per day, max of 365 days
Daily Hospital Intensive Care	$100 per day, max of 30 days
Hospital ICU Admission	$1,000 max of 1 per year

Rates	
Coverage Tier <69*	Radiologist Monthly Cost
Radiologist	$11.93
Radiologist + Spouse	$23.24
Radiologist + Child(ren)	$16.94
Radiologist + Family	$28.25

Voluntary Pet and Identity Theft Insurance

Pet Insurance

Insured by MetLife

Now more than ever, pets are playing a significant role in our lives, and it is important to keep them safe and healthy. **Help make sure your furry family members are protected against unplanned vet expenses for covered** accidents or illnesses with MetLife Pet Insurance.

- A small monthly payment can help you prepare for unexpected vet expenses down the road
- More than **6 in 10** pet owners said their pet has had an **emergency medical expense**
- 24% of **pet parents have credit card or personal loan debt** to cover pet health and vet costs
- Average annual cost for a routine vet visit is **$212 for a dog** and **$160 for a cat**; and average annual cost for a surgical vet visit is **$426** for a dog and **$214 for a cat**
- Pet insurance may not cover pre-existing conditions

To get a quote or enroll, please visit www.metlife.com/getpetquote or call 1 800 GET-MET8.

Identity Theft

Insured by Allstate

In today's world you can never be too safe with your personal and financial information. Allstate offers options to help protect you. Our society seems to be experiencing more and more scenarios that may put us at risk, so this is the best time to add protection that will help you relax a little easier at night. Should you become a victim of identity theft while enrolled in this product a dedicated team of specialists will work on your behalf to restore your identity.

Features:

Monthly Rates	
Radiologist Only	$9.95
Family	$17.95

- Identity and credit monitoring
- High risk transaction monitoring
- Dark web monitoring
- Data breach notifications
- Social media monitoring
- Protect yourself and your family ("under your roof and wallet")
- Remediation of pre-existing conditions at no additional cost
- Full-service 24/7 fraud remediation with a highly trained in-house expert
- $1 million identity theft insurance policy

Voluntary Legal Insurance

Insured by ARAG

Legal Insurance helps you address everyday situations like dealing with traffic tickets, resolving warranty issues or buying a home. ARAG offers top-performing legal insurance which features:

- In-Office Services: Meet with an experienced attorney who can advise and represent you when you need someone on your side.
- Telephone Advice: Talk to a knowledgeable professional over the phone when you need information and direction to address your legal matters.
- Online Resources: The ARAG Legal Center provides online tools and useful information to help you learn more about your legal issues on your own.

For more information call **800.247.4184** or visit **www.ARAGlegal.com** (Access code 18122vr).

ARAG Voluntary Legal Insurance		
	Ultimate Advisor	Ultimate Advisor Plus
Features	Consumer Issues, Estate planning, debt, civil damage defense, small claims court, family, real estate, criminal matters, taxes, traffic without DUI, disputes with a landlord, benefit disputes, general matters	All of the Ultimate Advisor coverage's and caregiving services, child support, child custody, alimony, additional divorce coverage, financial education, counseling services, identity theft protection
Price	$20.75 per month	$24.25 per month

401(k) Retirement Savings Plan

401(k) Retirement Savings Plan

The vRad 401(k) plan makes saving for retirement easy.

Eligibility

Administrative and record-keeping services for this Plan are provided by Charles Schwab. Radiologists who are at least 18 years of age and work at least 20 hours per week are eligible to participate the first of the month following your start date.

Contributions to the Plan

Contributions from your pay are made on a pretax basis. The IRS limit for 2025 is $23,500.

Catch-up Contributions

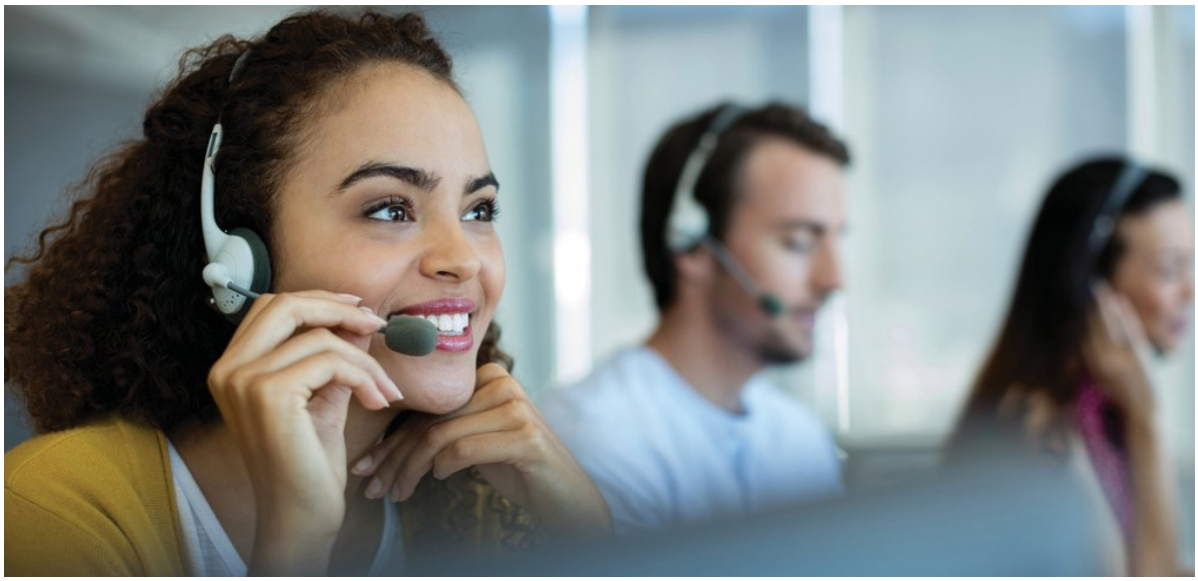
Radiologists 50 years of age or older, (or if you will reach age 50 by the end of the year), can make a catch-up contribution in addition to the normal IRS annual limit. The maximum annual catch-up contribution is $7,500 for 2025.

Investing in the Plan

You decide how to invest the assets in your account. Choose from the Managed Account Services path or Chart your own course by following the enrollment prompts to make your deferral elections. Best of all, your savings are tax deferred. vRad offers an automatic safe harbor and profit-sharing contribution of approximately 4.43% on a quarterly basis to all non-highly compensated employees. The IRS defines Highly Compensated Employees (HCEs) for the 2025 calendar year as those who made $155K or greater with vRad in 2024.

Contact Information

Plan	Provider	Phone	Website
Medical/Prescription Plans	HealthPartners	800.883.2177	www.healthpartners.com
Telehealth	VirtuWell	n/a	www.virtuwell.com
Dental	CIGNA	800.CIGNA24	www.myCigna.com
Vision	VSP	900.877.7195	www.vsp.com
Flexible Spending Account (FSA)	WEX	866.451.3399	www.wexinc.com/solutions/benefits/
Health Savings Account (HSA)	WEX	866.451.3399	www.wexinc.com/solutions/benefits/
Life and Accidental Death & Dismemberment (AD&D)	Unum	800.984.3840	www.Unum.com
Short-Term and Long-Term Disability	Unum	800.984.3940	www.Unum.com
Accident, Critical Illness, and Hospital	Unum	800.984.3940	www.Unum.com
Voluntary Legal Insurance	ARAG	800.247.4184	www.ARAGLegal.com (Access code 18122vr)
401(k)	Charles Schwab	800.724.7526	https://workplace.schwab.com/
Pet Insurance	MetLife	855.270.7387	www.metlife.com/getpetquote
Identity Protection	Allstate	855.821.2332	www.allstateidentityprotection.com



Notice of Creditable Coverage

Important Notice from Virtual Radiologic

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

When Can You Join a Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Virtual Radiologic coverage will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the plan's summary plan description or contact Medicare at the telephone number or web address listed herein. If you do decide to join a Medicare drug plan and drop your current Virtual Radiologic coverage, be aware that you and your dependents will not be able to get this coverage back.

Required Notices

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 Virtual Radiologic and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

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

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Virtual Radiologic 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: January 01, 2025
Name of Entity/Sender: Virtual Radiologic
Contact—Position/Office: Ashley Kivel - Human Resources Business Partner
Office Address: 3600 Minnesota Drive, Suite 800
Edina, MN 55435
United States
Phone Number: 952.595.1557

Required Notices

Women's Health & Cancer Rights Act

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

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

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

Plan 1: HealthPartners Platinum PPO (Individual: 20% coinsurance and $1,500 deductible; Family: 20% coinsurance and $4,500 deductible)

Plan 2: HealthPartners Gold HDHP (Individual: 20% coinsurance and $2,500 deductible; Family: 20% coinsurance and $5,000 deductible)

Plan 3: HealthPartners Silver HDHP (Individual: 20% coinsurance and $3,500 deductible; Family: 20% coinsurance and $7,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 952.595.1557 or Ashley.Kivel@vrad.com.

Newborns' and Mothers' Health Protection Act

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

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Virtual Radiologic is committed to the privacy of your health information. The administrators of the Virtual Radiologic Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Ashley Kivel - Human Resources Business Partner at 952.595.1557 or Ashley.Kivel@vrad.com.

Required Notices

HIPAA Special Enrollment Rights

Virtual Radiologic Health Plan Notice of Your HIPAA Special Enrollment Rights

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

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends
(or after the employer stops contributing toward the other coverage).

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

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

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Ashley Kivel - Human Resources Business Partner at 952.595.1557 or Ashley.Kivel@vrad.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

COBRA General Notice

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health 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: Ashley Kivel.

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[1] 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.

Required Notices

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

Virtual Radiologic
Ashley Kivel - Human Resources Business Partner
3600 Minnesota Drive, Suite 800
Edina, MN 55435
United States
952.955.1557

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Required Notices

Family and Medical Leave Act of 1993

You are eligible for leave under the Family and Medical Leave Act (FMLA) if you have been employed for a total of 12 months and worked at least 1,250 hours during the 12 months preceding the leave.

Eligible employees will receive up to 12 weeks of leave within any rolling 12-month period for the birth or adoption of a child, for the employee's own serious health condition or to care for a child, spouse, or parent with a serious health condition.

Eligible employees may also be eligible for FML leave to care for a family member who is a member of the Armed Forces under certain circumstances.

Genetic Information Nondiscrimination Act 2008 (GINA)

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

Patient Protections Disclosure

The Virtual Radiologic Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, HealthPartners designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the HealthPartners at 800.883.2177 or www.healthpartners.com.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from HealthPartners or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the HealthPartners at 800.883.2177 or www.healthpartners.com.

Required Notices

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –

ALABAMA - Medicaid

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ARKANSAS - Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

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 Services: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI)
https://mycohibi.com/
HIBI Customer Service: 1-855-692-6442

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

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

FLORIDA - Medicaid

Website: https://www.flmedicaidtplrecovery.com/
flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

Required Notices

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

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

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

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

MINNESOTA - Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

NEVADA - Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

INDIANA - Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/hip/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

KANSAS - Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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)

MASSACHUSETTS - Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

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

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. 5218
Email: DDHS.ThirdPartyLiabi@dhhs.nh.gov

Required Notices

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)

NORTH CAROLINA - Medicaid

Website: https://medicaid.ncdhs.gov/
Phone: 919-855-4100

OKLAHOMA - Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

PENNSYLVANIA - Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

SOUTH CAROLINA - Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

TEXAS - Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

VERMONT - Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

NEW YORK - Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH DAKOTA - Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OREGON - Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

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 DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

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/

VIRGINA - 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

Required Notices

WASHINGTON - Medicaid
Website: http://www.hca.wa.gov/ Phone: 1-800-562-3022
WISCONSIN - Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

WEST VIRGINA - Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ https://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (855-699-8447)
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, 2024, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

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

Marketplace Notice

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 9.12%[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.[1 2]

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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.

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.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Brittany O'Fallon.

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 Virtual Radiologic		4. Employer Identification Number (EIN) 27-0074530
5. Employer address 3600 Minnesota Drive, Suite 800		6. Employer phone number 952.595.1557
7. City Edina	8. State Minnesota	9. ZIP code 55435
10. Who can we contact about employee health coverage at this job? Ashley Kivel		
11. Phone number (if different from above)	12. Email address Ashley.Kivel@vrad.com	

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

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

X All employees. Eligible employees are: Radiologist who works 30 hours or more each week.

☐ Some employees. Eligible employees are:

- With respect to dependents:

X We do offer coverage. Eligible dependents are: Your legal spouse, Natural, adopted or step-children up to age 26.

☐ We do not offer coverage.

X If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

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

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

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

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13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? (mm/dd/yyyy) (Continue)
☐ **No**

---

14. Does the employer offer a health plan that meets the minimum value standard[3]?

☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

---

15. For the lowest cost plan that meets the minimum value standard[3] offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan?
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

---

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

---

16. What change will the employer make for the new plan year?
    - ☐ Employer won't offer health coverage
    - ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.[3] (Premium should reflect the discount for wellness programs. See question 15.)

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

[3] 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 (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

OMB Control Number: 0938-1401
Expiration Date: 05/31/2025

Your Rights and Protections Against Surprise Medical Bills

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

What is "balance billing" (sometimes called "surprise billing")?

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

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

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

You are protected from balance billing for:

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

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

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

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

When balance billing isn't allowed, you also have the following protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact https://www.cms.gov/nosurprise/consumers or call 1-800-985-3059 to obtain more information and complaints.

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

Visit State Balance-Billing Protections | Commonwealth Fund for more information about your rights under applicable state laws.

California HIPP Notice

State of California
Health and Human Services Agency
Department of Health Care Services

Health Insurance Premium Payment (HIPP) Program
DISCLOSURE STATEMENT
(Required)
Please read entire disclosure statement before signing.

The California Department of Health Care Services (DHCS) will pay, when it is cost-effective to do so, medical insurance premiums for full scope Medi-Cal beneficiaries who have a high cost medical condition. As an applicant or enrollee, you must submit the policy booklet or Evidence of Coverage from your individual or group health insurance carrier, a Statement of Diagnosis Medical Report signed and dated within six (6) months of the date of application and other requested documentation. The following applies to all applicants and enrollees of the HIPP Program, effective July 1, 2014.

1. Purchasing or paying for health insurance coverage is not cost-effective when a court has ordered a non custodial parent to provide medical insurance, a Medi-Cal beneficiary is also enrolled in Medicare, an individual or employee has been fully reimbursed for his/her payment of health care premiums, and a beneficiary is also enrolled in a Medi-Cal managed care plan.

2. HIPP does not pay for premiums paid prior to the month the application was received by HIPP or for past due premiums. If premiums are past due, the applicant must bring the premiums current before approval can be determined.

3. HIPP pays medical insurance premiums, coinsurance, deductibles, and other cost-sharing obligations.

4. The California Code of Regulations, Title 22, Section 50763(a) (1) states, “An applicant or beneficiary shall: apply for, and/or retain any available health care coverage when no cost is involved.” This means that if you drop your private health coverage without DHCS approval after the state begins paying your premiums, you could lose your Medi-Cal benefits.

5. As a condition of HIPP eligibility, any reimbursement received for medical coverage premiums must be forwarded to DHCS.

6. It is the responsibility of the HIPP enrollee to notify the HIPP Program within ten (10) days of any changes in health insurance coverage, insurance premium amount, personal contact information, marital status, or any changes that may otherwise affect the HIPP Program eligibility.

7. Each case is redetermined at least annually to determine if the case remains cost-effective for the state to pay the medical insurance premiums. Failure to submit required documents for redetermination may result in disenrollment from the HIPP program.

8. A HIPP enrollee may be terminated from the program if their Medi-Cal eligibility is terminated, their private health coverage is terminated, the enrollee is Medicare eligible, they fail to provide requested information, or if it is no longer cost-effective for DHCS to pay the medical insurance premiums. Only one letter of termination will be mailed to the address of record.

9. In accordance with All County Welfare Directors Letter No. 95-82, there are no appeal rights for the HIPP Program.

10. Funding for the HIPP Program is contingent upon a state budget. In the event a state budget is not enacted timely, HIPP payments may be delayed. If HIPP payments are delayed, HIPP enrollees, in order to avoid the potential loss of their health insurance, may be personally responsible for making the insurance premium payments. DHCS will reimburse those payments once a state budget has been enacted.

CERTIFICATION: I certify that I have thoroughly read the provisions listed above, and I understand and agree to them.

Name of Applicant *(print)*:	Signature of Applicant/Guardian:	Date:
Name of Policyholder *(print)*:	Signature of Policyholder:	Date:

PLEASE RETAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

DHCS 9121 (Rev. 06/19)

Required Notices

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting

VRS/ vRad