

2026



Employee Benefits

rightsline™

2 Table of Contents

Rightsline is proud to support our employees' overall wellbeing with a variety of benefit options. This guide offers details on our 2026 offerings for you and your family. Contact the People Success Team department with any questions.

3	Eligibility and Enrollment
5	Ready for Open Enrollment?
6	Medical Benefits
12	Pharmacy Benefits
13	Health Savings Account
15	Flexible Spending Accounts
17	FSA vs HSA
18	Dental Benefits
19	Vision Benefits
20	Survivor Benefits
23	Income Protection
24	Mental Health
25	Additional Benefits
26	Glossary
28	Required Notices
30	Important Contacts



See **page 28** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to Critical Mass Studios, Inc. dba Rightsline. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

3

Eligibility and Enrollment

Rightsline's benefits are designed to support your unique needs.

Eligibility

If you are a full-time employee of Rightsline who is regularly scheduled to work at least 30 hours a week, you are eligible to participate in medical, dental, vision, life and disability plans, and additional benefits.

Coverage Dates

Your elections are effective January 1, 2026, or date of hire if hired after January 1, 2026. Benefits cannot be changed until the next enrollment period unless you experience a Qualifying Life Event.

Passive Enrollment

All of your current benefit elections will roll over into the new plan year if no action is taken. The only plans that require an active election are the FSA and HSA. Any new elections you make or those that roll over will remain in place until the following enrollment period unless you experience a Qualifying Life Event.

Dependents

Dependents eligible for coverage include:

- » Your legal spouse (or common-law spouse where recognized).
- » Your registered domestic partner.
- » Children under the age of 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children, and children for whom you or your spouse have legal guardianship).
- » Dependent children 26 or more years old, unmarried, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility may be required upon enrollment.



Now's the Time to Enroll!

What Are Qualifying Life Events?

You can update your benefits when you start a new job or during Open Enrollment each year. But changes in your life called Qualifying Life Events (QLEs) determined by the IRS can allow you to enroll in health insurance or make changes outside of these times.

When a Qualifying Life Event occurs, you have 31 days to request changes to your coverage. Your change in coverage must be consistent with your change in status.



A change in the number of dependents (through birth or adoption or if a child is no longer an eligible dependent)



A change in a spouse's employment status (resulting in a loss or gain of coverage)



A change in employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility



Entitlement to Medicare or Medicaid



Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)



Death in the family (leading to change in dependents or loss of coverage)



Turning 26 and losing coverage through a parent's plan



Changes in address or location that may affect coverage



Eligibility for coverage through the Marketplace ([Healthcare.gov](https://www.healthcare.gov))



A change in your legal marital status (marriage, divorce, or legal separation)

Reach out to Rightsline's People Success Team with questions regarding specific life events and your ability to request changes. Don't miss out on a chance to update your benefits!

5

Ready for Open Enrollment?

Rightsline covers a significant amount of your benefit costs. Your contributions for medical, dental, and vision benefits are deducted on a pre-tax basis, which reduces the amount you're required to pay taxes on. Employee contributions vary depending on the level of coverage you select — typically, the more coverage you have, the more you'll pay up-front for it.

Open Enrollment Action Items



Update your personal information.

Confirm your mailing address and phone number are up to date.



Add your dependents in BambooHR.

Navigate to the My Info tab and click Benefits on the employee profile. Scroll down to the Dependents table and click +Add Dependent.



Double-check covered medications.

If you make any changes to your plan, consider how it affects your prescriptions (i.e., will their costs go up or down?).



Review available plans' deductibles.

Think you may have more medical needs than usual this year? You might want a lower deductible. If not, you could switch to a higher deductible plan and enjoy lower premiums out of your paycheck.



Consider your HSA or FSA.

An HSA or FSA can help cover healthcare costs, including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with your long-term financial goals.



Check your networks.

Receiving care by in-network providers often saves you money. Check for any plan changes to make sure your go-to providers and pharmacy are still your best bet.



6

Medical Benefits

Medical benefits are provided through Cigna. Consider the physician networks, premiums, and out-of-pocket costs for each plan when making a selection. Keep in mind your choice is effective for the entire 2026 plan year unless you have a Qualifying Life Event.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your semimonthly contributions.

	HDHP	BASE COPAY	BUY-UP COPAY
SEMIMONTHLY CONTRIBUTIONS			
EMPLOYEE ONLY	\$67.12	\$81.53	\$126.07
EMPLOYEE + SPOUSE	\$227.42	\$294.28	\$379.87
EMPLOYEE + CHILD(REN)	\$200.84	\$259.88	\$335.47
EMPLOYEE + FAMILY	\$298.30	\$386.00	\$498.26

To search the Cigna provider network before your plan starts, go to cigna.com, and click on "Find a Doctor" at the top of the screen. Then, under "How are you Covered?" select "Employer or School."

Choose the Right Provider Once Enrolled

- » Know which providers are in your network by going to myCigna.com > Find Care & Costs
- » Choose providers who have received the Cigna Care Designation – high-performance recognition given to physicians in certain specialties who meet Cigna quality and medical cost-efficiency standards
- » Opt to connect with a board-certified doctor, therapist, or psychiatrist via video or phone
- » Use in-network national labs to help save money

Note

To get the most value out of your medical plan, be sure to visit in-network providers whenever possible.



Medical Plan Summary

This chart summarizes the 2026 medical coverage provided by Cigna. The Cigna medical plans utilize the Cigna OAP network. All covered services are subject to medical necessity as determined by the plan. Please note that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	HDHP		BASE COPAY		BUY-UP COPAY	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE						
INDIVIDUAL	\$3,500	\$7,000	\$3,500	\$7,000	\$1,000	\$5,000
FAMILY	\$7,000	\$14,000	\$7,000	\$14,000	\$2,000	\$10,000
COINSURANCE (PLAN PAYS)	80%	50%	80%	50%	80%	50%
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)						
INDIVIDUAL	\$5,000	\$15,000	\$7,000	\$15,000	\$3,500	\$15,000
FAMILY	\$10,000	\$30,000	\$14,000	\$30,000	\$7,000	\$30,000
COPAYS/COINSURANCE (YOU PAY)						
PREVENTIVE CARE	Covered 100%	Not covered	Covered 100%	Not covered	Covered 100%	Not covered
PRIMARY CARE	20%*	50%*	\$30	50%*	\$20	50%*
SPECIALIST SERVICES	20%*	50%*	\$50	50%*	\$40	50%*
DIAGNOSTIC CARE	20%*	50%*	20%*	50%*	20%*	50%*
URGENT CARE	20%*	50%*	\$75	50%*	\$50	50%*
EMERGENCY ROOM	20%*		\$300 + 20%		\$300 + 20%	

*After deductible

The individual deductible amount must be met by each member enrolled under your medical coverage. If you have several covered dependents, all charges used to apply toward a “per individual” deductible amount will also be applied toward the “per family” deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be met for the remainder of that plan year. No member may contribute more than the individual deductible amount to the “per family” deductible amount. The same typically applies for the out-of-pocket maximum.

Cigna One Guide

Combining digital technology with our personalized customer service over the phone or on the myCigna app, the Cigna One Guide support tool can help you:

- » Resolve healthcare issues
- » Save time and money
- » Get the most out of your plan
- » Find the right hospitals, dentists, and other healthcare providers in your plan’s network
- » Get cost estimates
- » Understand your bills
- » Navigate the healthcare system

8

Out-of-Pocket Costs

These are the types of payments you're responsible for:

Copay

The fixed amount you pay for healthcare services at the time you receive them.

Coinsurance

Your percentage of the cost of a covered service. If your office visit is \$100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be \$20.

Deductible

The amount you must pay for covered services before your insurance begins paying its portion/coinsurance.

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

9

Preventive Care

Routine checkups and screenings are considered preventive, so they're often paid at 100% by your insurance. Some common covered services include:



Wellness visits, physicals, and standard immunizations



Screenings for blood pressure, cancer, cholesterol, depression, obesity, and diabetes



Pediatric screenings for hearing, vision, obesity, and developmental disorders



Anemia screenings, breastfeeding support, and pumps for pregnant and nursing women



Iron supplements (for infants at risk for anemia)



It's important to take advantage of these covered services. But remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. So, if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

What Vaccines Are Covered 100% Under Preventive Care?

Many vaccines are covered under preventive care when delivered by a doctor or provider in your plan's network. These include chickenpox, flu, shingles, and tetanus. For a full list, visit www.healthcare.gov/preventive-care-adults.

10 Where to Go for Care

You're feeling sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new prescription, but the pharmacy is closed. Or you're on vacation and are under the weather. Instead of rushing to the emergency room or relying on questionable information from the internet, consider all of your site-of-care options.



Nurse Line

When to Use

You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

Types of Care*

Answers to questions regarding:

- » Symptoms
- » Self-care/home treatments
- » Medications and side effects
- » When to seek care

Costs and Time Considerations**

- » Usually available 24 hours a day, 7 days a week
- » Typically free as part of your medical insurance



Telemedicine (\$)

When to Use

You need care for minor illnesses and ailments but would prefer not to leave home. These services are available by phone and online (via webcam).

Types of Care*

- » Cold & flu symptoms
- » Bronchitis
- » Urinary tract infection
- » Sinus problems

Costs and Time Considerations**

- » Usually a first-time consultation fee and a flat fee or copay for any visit thereafter
- » Typically immediate access to care
- » Prescriptions through telemedicine or virtual visits not allowed in all states



Primary Care Center (\$)

When to Use

You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

Types of Care*

- » Routine checkups
- » Immunizations
- » Preventive services
- » Managing your general health

Costs and Time Considerations**

- » Often requires a copay and/or coinsurance
- » Normally requires an appointment
- » Short wait time with scheduled appointment

*This is a sample list of services and may not be all inclusive.

**Costs and time information represent averages only and are not tied to a specific condition or treatment.



Urgent Care Center (\$\$)

When to Use

You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

Types of Care*

- » Strains, sprains
- » Minor broken bones (e.g., finger)
- » Minor infections
- » Minor burns

Costs and Time Considerations**

- » Copay and/or coinsurance usually higher than an office visit
- » Walk-in patients welcome, but urgency determines order seen and wait time



Emergency Room (\$\$\$)

When to Use

You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

Types of Care*

- » Heavy bleeding
- » Chest pain
- » Major burns
- » Severe head injury

Costs and Time Considerations**

- » Often requires a much higher copay and/or coinsurance
- » Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first
- » Ambulance charges, if applicable, will be separate and may not be in-network

*This is a sample list of services and may not be all inclusive.

**Costs and time information represent averages only and are not tied to a specific condition or treatment.

Do Your Homework

What may seem like an urgent care center might actually be a standalone ER. These facilities come with a higher price tag, so ask for clarification if the word “emergency” appears in the company name.

12 Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through Cigna. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at www.mycigna.com or by calling the Customer Care number on your ID card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred Brand, Non-Preferred Brand, or Specialty.

	HDHP	BASE COPAY	BUY-UP COPAY
	IN-NETWORK ONLY	IN-NETWORK ONLY	IN-NETWORK ONLY
RETAIL RX (30-DAY SUPPLY)			
GENERIC	20%*	\$10	\$10
PREFERRED BRAND	20%*	\$35	\$35
NON-PREFERRED BRAND	20%*	\$60	\$60
SPECIALTY	20%*	\$250	\$250
MAIL ORDER RX (90-DAY SUPPLY)			
GENERIC	20%*	\$25	\$25
PREFERRED BRAND	20%*	\$88	\$88
NON-PREFERRED BRAND	20%*	\$150	\$150

*After deductible

To view your new drug list before your Cigna plan starts, go to cigna.com/PDL.

Find Where to Get Prescription Drugs

- » Find the complete list of covered medications on myCigna.com
- » Use cost-comparison tools on myCigna to compare prices and purchase mail-order prescriptions
- » Use generics when possible
- » Know what brand-name drugs are covered in your plan
- » Ask your doctor about a 90-day supply for your maintenance medication(s) through our home delivery pharmacy service

Note

Apps and prescription discount programs such as GoodRx, Amazon Prime Rx Savings, Optum Perks, and Cost Plus Drug Company let you compare prices of prescription drugs and find possible discounts.



13 Health Savings Account

Want funds handy to help cover out-of-pocket healthcare expenses? A Health Savings Account (HSA) with Lively is a personal healthcare bank account used to pay for qualified medical expenses. HSA contributions and withdrawals for qualified healthcare expenses are tax-free. You must be enrolled in an HDHP to participate.

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in an HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

Lively will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses – no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to contribute to an HSA if:

- » You are enrolled in an HSA-eligible High Deductible Health Plan.
- » You are not covered by a non-HDHP plan, including your spouse's or parent's plan.
- » You do not, or your spouse does not, have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- » You are not eligible to be claimed as a dependent on someone else's tax return.
- » You are not enrolled in Medicare or TRICARE.
- » You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

Note

Because HSA funds never expire, contributing your annual maximum to your HSA can help you save to pay for healthcare expenses tax-free after retirement.



You Own Your HSA

Your HSA is a personal bank account that you own and manage. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements (you own all contributed HSA funds immediately) or forfeiture provisions (you keep all HSA funds whether you leave the company or retire).

How to Enroll

To enroll in Rightsline's HSA, you must elect the HDHP with Rightsline. Submit all HSA enrollment materials and choose the amount to contribute on a pre-tax basis. Rightsline will establish an HSA account in your name and send in your contribution once bank account information has been provided and verified.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with Lively. The money in your HSA (including interest and investment earnings) grows tax-free. When the funds are used for qualified medical expenses, they are spent tax-free.*

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax. This is why it's important to know what medical expenses qualify for HSA use and to keep track of where you spend your HSA funds.

*State income taxes are also waived on HSA contributions in almost all states.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2026, contributions are limited to the following:

2026 ANNUAL HSA FUNDING LIMITS	
EMPLOYEE	\$4,400
FAMILY	\$8,750
CATCH-UP CONTRIBUTION (AGES 55+)	\$1,000

HSA contributions over the IRS annual contribution limits (\$4,400 for individual coverage and \$8,750 for family coverage for 2026) are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- » Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed but won't have to pay a penalty tax.
- » Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year, consider contributing less than the annual limit to your HSA.

The Rightsline HSA is established with Lively. You may be able to roll over funds from another HSA. For more enrollment information, contact People Success Team or visit livelyme.com.



15 Flexible Spending Accounts

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

With a Lively Healthcare FSA, you can contribute up to \$3,400 annually for qualified medical expenses (deductibles, copays, coinsurance, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them – no waiting for reimbursement.

Note

The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.

Limited Use Flexible Spending Account

A Limited Use Flexible Spending Account (LUFSA) with Lively works with a Health Savings Account (HSA) and allows for reimbursement of eligible dental and vision expenses. The contribution limit is \$3,400.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA – even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- » With the Dependent Care FSA, you can set aside up to \$7,500 to pay for child or elder care expenses on a pre-tax basis.
- » Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- » You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent daycare expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- » In-home babysitting services (not provided by a dependent)
- » Care of a preschool child by a licensed nursery or daycare provider
- » Before- and after-school care
- » Day camp
- » In-house dependent daycare

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.



Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact Lively with reimbursement questions. If you need to submit a receipt, Lively will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges in case you need to prove an expense was eligible. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:









- » Expenses must occur during the 2026 plan year.
- » Funds cannot be transferred between FSAs.
- » You are not permitted to claim the same expenses on both your federal income taxes and Dependent Care FSA.
- » You must “use it or lose it” – any unused funds will be forfeited.
- » Up to \$680 may be rolled over to the next plan year at the end of 2026 for Healthcare FSAs.
- » You cannot change your FSA election in the middle of the plan year without a Qualifying Life Event.
- » Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- » Those considered highly compensated employees (family gross earnings were \$160,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.



17 FSA vs HSA

Flexible Spending Accounts

Health Savings Account

<p>Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.</p>	 <p>OWNERSHIP</p>	<p>You own your HSA. It is a savings account in your name, and you always have access to the funds, even if you change jobs.</p>
<p>You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.</p>	 <p>ELIGIBILITY & ENROLLMENT</p>	<p>You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.</p>
<p>FSA contributions are tax-free via payroll deduction. Funds are spent tax-free when used for qualified expenses.</p>	 <p>TAXATION</p>	<p>HSA contributions are tax-free; the account grows tax-free; and funds are spent tax-free on qualified expenses.</p>
<p>You can contribute up to \$3,400 in 2026 to an FSA. This amount may be increased annually by the IRS.</p>	 <p>CONTRIBUTIONS</p>	<p>You can contribute up to \$4,400 in 2026 (up to \$8,750 for families). Ages 55+ can make an annual \$1,000 "catch-up" HSA contribution.</p>
<p>Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.</p>	 <p>PAYMENT</p>	<p>Many HSAs include a debit card to pay for qualified expenses directly. Alternatively, you can save funds for future expenses or retirement.</p>
<p>Any unclaimed funds at the end of the year are forfeited. Exceptions might include an allowed rollover amount.</p>	 <p>ROLLOVER OR GRACE PERIOD</p>	<p>HSA funds roll over from year to year. The account is portable and may be used for future qualified expenses – even in retirement years.</p>
<p>Physician services, hospital services, prescriptions, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.</p>	 <p>QUALIFIED EXPENSES</p>	<p>Physician services, hospital services, prescriptions, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.</p>
<p>Dependent Care FSA (pre-tax dollars can be used for elder or child dependent care), Limited Use FSA (used to pay for eligible dental and vision expenses).</p>	 <p>OTHER TYPES</p>	<p>There is only one type of HSA.</p>

Please refer to your summary plan description or plan certificate for your plan's specific FSA or HSA benefits.

18 Dental Benefits

Like brushing and flossing, visiting your dentist is an essential part of your oral health. Rightsline offers affordable plan options from Cigna for routine care and beyond.

Stay in Network

Total Cigna DPPO Network dentists have agreed to reduce their fees for Cigna customers. They will also file the claims for you, and they cannot "balance bill" you for the difference between their regular fees and the reduced fees they have agreed to accept from Cigna. To find a network dentist, visit Cigna at www.mycigna.com.

Dental Premiums

Dental premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your semimonthly premium.

Dental Plan Summary

This chart summarizes the dental coverage provided by Cigna for 2026.

	BASE DPPO	BUY-UP DPPO
SEMIMONTHLY CONTRIBUTIONS		
EMPLOYEE ONLY	\$3.62	\$5.28
EMPLOYEE + SPOUSE	\$10.88	\$14.23
EMPLOYEE + CHILD(REN)	\$12.10	\$15.91
EMPLOYEE + FAMILY	\$18.77	\$24.57
	BASE DPPO	BUY-UP DPPO
ANNUAL DEDUCTIBLE		
INDIVIDUAL	\$100	\$50
FAMILY	\$300	\$150
ANNUAL MAXIMUM		
PER PERSON	\$1,250	\$1,250
COVERED SERVICES		
PREVENTIVE SERVICES Oral Exams, Routine Cleanings, Bitewing X-rays, Fluoride Applications, Sealants, Space Maintainers, Panoramic X-rays	100%	100%
BASIC SERVICES Fillings, Oral Surgery, Simple Extractions, Endodontics, Periodontics	70%*	80%*
MAJOR SERVICES Crowns, Dentures, Bridges	50%*	60%*
ORTHODONTICS Dependent Child(ren) Only	50%	50%
ORTHODONTIC LIFETIME MAXIMUM PER PARTICIPANT	\$2,000	\$2,000

*After deductible

Tips: What Is Balance Billing?

Balance billing happens when a dentist who isn't in your plan's network charges more than your plan pays. Balance billing is a risk when you get services from an out-of-network dentist. So it helps to understand the difference between in-network and out-of-network dentists.

19 Vision Benefits

Getting your eyes checked regularly is important even if you don't wear glasses or contacts. We provide quality vision care for you and your family through EyeMed.

Vision Premiums

Vision premium contributions are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your semimonthly premium.

Vision Plan Summary

This chart summarizes the vision coverage provided by EyeMed for 2026.

VISION			
SEMIMONTHLY CONTRIBUTIONS			
EMPLOYEE ONLY		\$0.57	
EMPLOYEE + SPOUSE		\$1.63	
EMPLOYEE + CHILD(REN)		\$1.72	
EMPLOYEE + FAMILY		\$2.53	
		IN-NETWORK	OUT-OF-NETWORK
			FREQUENCY
EXAMS			
	COPAY	\$10 copay \$0 copay at PLUS providers*	\$40 allowance
			12 months
LENSES			
	SINGLE VISION	\$25 copay	\$30 allowance
	BIFOCAL	\$25 copay	\$50 allowance
	TRIFOCAL	\$25 copay	\$70 allowance
	LENTICULAR	\$25 copay	\$70 allowance
			12 months
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
	FITTING AND EVALUATION	Up to \$40	Not covered
	ELECTIVE	\$150 allowance \$200 allowance at PLUS providers*	\$105 allowance
	MEDICALLY NECESSARY	Covered in full	\$300 allowance
			12 months
FRAMES			
	COPAY	\$0	Not applicable
	ALLOWANCE	\$150 allowance \$200 allowance at PLUS providers*	\$105 allowance
			24 months

*PLUS providers add another layer of coverage and are designed to help you save even more.



The choice is yours

Find plenty of in-network eye doctors – including PLUS Providers – on our Provider Locator. Just look for the PLUS.

Need extra assistance? Contact us at 1.866.939.3633 or visit eyemed.com.



20 Survivor Benefits

It's hard to think about, but it's important to have a plan in place to provide for your family if something were to happen to you. Survivor benefits provide financial protection for your loved ones in the event of an unexpected event.

Basic Life and Accidental Death & Dismemberment Insurance

Rightsline provides employees with Basic Life and Accidental Death and Dismemberment (AD&D) insurance as part of your basic coverage through New York Life, which guarantees that your spouse or other designated survivor(s) continue to receive benefits after death.

Your Basic Life and AD&D insurance benefit is \$50,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you waive other coverage.

Naming a Beneficiary

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life. You receive the benefit payment for a dependent's death under the New York Life insurance.

Name a primary and contingent beneficiary to make your intentions clear. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches age 18. Contact People Success Team or your own legal counsel with any questions.



Voluntary Life and AD&D Insurance

You may wish for extra coverage for more peace of mind. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions.

BASIC EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	Flat \$50,000
WHO PAYS	Rightsline
BENEFITS PAYABLE	Upon employee's death
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Not required
VOLUNTARY EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	1x, 2x, 3x, 4x, or 5x Salary
WHO PAYS	Employee
BENEFITS PAYABLE	Upon employee's death
MAXIMUM BENEFIT	\$750,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	\$150,000
VOLUNTARY SPOUSE LIFE/AD&D	
COVERAGE AMOUNT	Increments of \$5,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon spouse's death
MAXIMUM BENEFIT	Lesser of 100% of employee election; or \$250,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	\$25,000
VOLUNTARY CHILD LIFE/AD&D	
COVERAGE AMOUNT	Increments of \$1,000
WHO PAYS	Employee
BENEFITS PAYABLE	Upon child's death
MAXIMUM BENEFIT	\$10,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	Not required

Note: If you waive coverage as a new hire, EOI will be required to enroll or increase your coverage during a subsequent enrollment period.

Benefits are subject to age reduction schedule of:

- » 65% at age 65
- » 50% at age 70

VOLUNTARY LIFE/AD&D INSURANCE	
RATES/\$1,000 (MONTHLY)	
AGE (AS OF JANUARY 1, 2026)	EMPLOYEE
Under 25	\$0.056
25 to 29	\$0.084
30 to 34	\$0.089
35 to 39	\$0.090
40 to 44	\$0.142
45 to 49	\$0.200
50 to 54	\$0.430
55 to 59	\$0.574
60 to 64	\$0.705
65 to 69	\$1.292
70 and over	\$19.683

VOLUNTARY LIFE/AD&D INSURANCE	
RATES/\$1,000 (MONTHLY)	
\$0.020	

VOLUNTARY CHILD LIFE/AD&D INSURANCE	
RATES/\$1,000 (MONTHLY)	
\$0.020	

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE/AD&D COVERAGE WILL COST:

\$	÷ 1,000 =	\$	x (Age Based Rate + AD&D Rate) =	\$
Benefit Elected				Monthly Premium

To calculate your per pay period semimonthly cost, divide the monthly premium by 2.

23 Income Protection

You and your loved ones depend on your regular income. That's why Rightsline offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury or illness. A portion of your income is protected until you can return to work or you reach retirement age.

Short-Term Disability (STD) Insurance

STD benefits are available at no cost. This insurance replaces 60% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or People Success Team for details.

WEEKLY MAXIMUM BENEFIT	\$2,800
ELIMINATION PERIOD	7 days
MAXIMUM BENEFIT PERIOD	12 weeks

Long-Term Disability (LTD) Insurance

LTD benefits are available at no cost. This insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or People Success Team for details.

MONTHLY MAXIMUM BENEFIT	\$12,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.



24 Mental Health

You visit your doctor when you're feeling sick, and you exercise and eat healthy to keep your body strong. But your mental health is just as important. What do you do to stay healthy mentally? Do you know where you can go when you need help? Whether you need assistance with work-life balance or anxiety, there are resources available to help you out.

Employee Assistance Program

We're here for you when you need help. Our Employee Assistance Program (EAP) helps you and your family manage your total health, including mental, emotional, and physical. And there's no cost to you – whether or not you're enrolled in a company-sponsored medical plan.

Through the EAP, you have access to mental health assistance and legal and financial help from professionals. You also have 24-hour access to helpful resources by phone and a designated number of face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with Rightsline. You may access information, benefits, educational materials, and more by phone at 800-344-9752 or online at www.guidanceresources.com.

The Program provides referrals to help with:

- » Emotional health and wellbeing
- » Alcohol or drug dependency
- » Marriage or family problems
- » Job pressures
- » Stress, anxiety, depression
- » Grief and loss
- » Financial or legal advice

Mental Health and Your Medical Plan

When your covered EAP services run out, the medical plan covers behavioral and mental health services. Coverage includes virtual therapy from Cigna. Via video or telephone, you can receive confidential 1-on-1 counseling from the privacy and convenience of your home. Your licensed virtual therapist may provide a diagnosis, treatment, and medication if needed. You can see the same therapist with each appointment and establish an ongoing relationship. See plan documents for specifics on coverage for inpatient and outpatient services. Your health plan coverage also includes the MDLIVE app for an online option for behavioral health therapy. This tool provides access to providers for virtual visits through text or video. Call 888-726-3171 or visit mycigna.com for more information or to sign up.

The Big Five of Emotional Wellness

An important aspect of your overall wellbeing is emotional wellness – the ability to successfully adapt to changes and challenges as they arrive and handle life's stresses. These five actions have been shown to improve emotional wellness.



Practice mindfulness.

Practice deep breathing, take a walk, enjoy nature, and stay present in each moment.



Strengthen social connections.

Reach out to a friend or family member daily – even if it's just a call or text.



Get quality sleep.

Keep a consistent sleep schedule and limit electronic use before bed.



Improve your outlook.

Treat people with kindness, including yourself.



Deal with your stress in healthy ways.

Think positively, exercise regularly, and set priorities.

25 Additional Benefits

Rightsline wants you to succeed in all aspects of life, so we offer a variety of additional benefits to make your day-to-day easier.

Beneficiary Assist Program

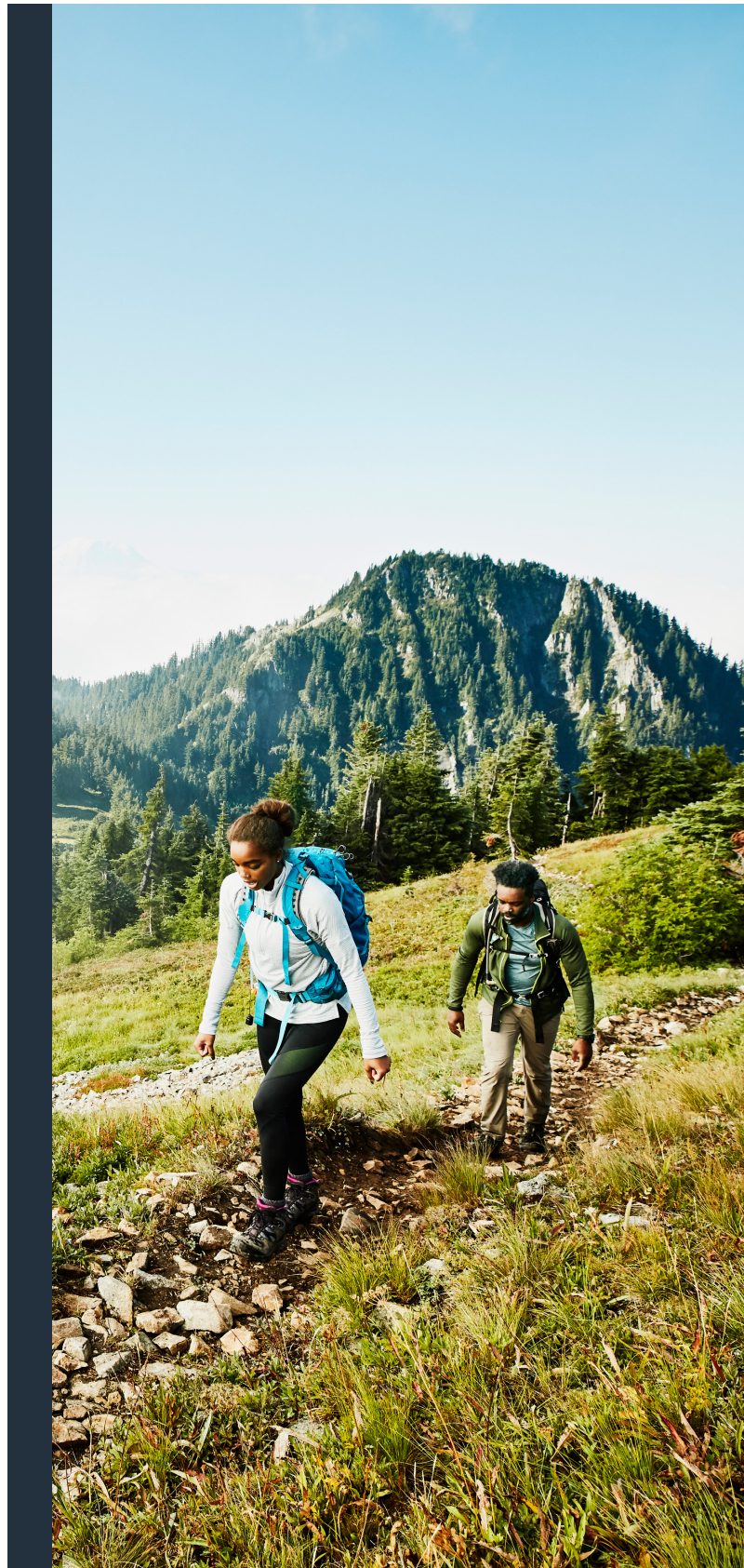
Rightsline is here for you during your grief. Our Beneficiary Assist Program through New York Life provides assistance with the emotional, financial, and legal issues that arise after the loss of a loved one. This program is offered at no cost to beneficiaries of the Group Life or Accident plans. Call 800-344-9752 to access loss counseling and financial/legal professionals on a confidential basis. Services include:

- » Emotional support for you and your family members at no additional cost. Accessible 24 hours a day, 7 days a week.
- » Work/life assistance, coaching, online articles, resources and, videos.
- » Professional support for all types of pressing financial, legal, or estate issues; includes law consultations, tax consultations, credit and tax questions, and much more.

Travel Assistance

With the Travel Assistance Program, toll-free emergency assistance is available to you and your dependents 24 hours a day, 7 days a week, when traveling 100 or more miles from your primary home for less than 90 days.

- » Pre-trip planning assistance, including inoculation and visa requirements in foreign countries; information about cultural and special events; temperature and weather information; foreign exchange rates.
- » Language interpretation by telephone and referrals to embassies or consulates in an emergency.
- » Assistance with locating or replacing lost or stolen items, medications or travel documents; assistance locating medical or dental providers.
- » Emergency cash advances (up to \$1,500) and emergency medical payment advances (up to \$10,000), when secured with a credit card. Please note that medical benefits are not provided, and all costs of medical treatment are the responsibility of the patient or his or her medical insurance carrier.
- » Repatriation of your remains if you die while traveling.



26 Glossary

Balance Billing – When you are billed by a provider for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is \$100 and the allowed amount is \$60, you may be billed by the provider for the remaining \$40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount you pay for healthcare services received, as determined by your insurance plan.

Deductible – The amount you owe for healthcare services before your insurance begins to pay its portion. For example, if your deductible is \$1,000, your plan does not pay anything until you’ve paid \$1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer’s decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You’ll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are “use it or lose it,” so funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or rollover into the next plan year.

- » **Healthcare FSA** – A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren’t covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- » **Dependent Care FSA** – A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.
- » **Limited Use FSA** – Designed to complement a Health Savings Account, a Limited Use FSA allows for reimbursement of eligible dental and vision expenses.

Healthcare Cost Transparency – Also known as market transparency or medical transparency. Online cost transparency tools, available through health insurance carriers, allow you to search an extensive national database to compare varying costs for services.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer’s tax-free dollars to pay for qualified medical expenses. You must be enrolled in an HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable if you change jobs.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility, and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, and all qualified employee-paid medical expenses count toward your deductible and out-of-pocket maximum.

Network – A group of physicians, hospitals, and healthcare providers that have agreed to provide medical services to a health insurance plan’s members at discounted costs.

- » **In-Network** – Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- » **Out-of-Network** – Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.



Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage.

Out-of-Pocket Maximum – The most you pay during the plan year before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, out-of-network provider charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred brand, non-preferred brand, or specialty.

- » **Generic Drugs** – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- » **Preferred Brand Drugs** – Brand-name drugs on your provider's approved list (available online).
- » **Non-Preferred Brand Drugs** – Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- » **Specialty Drugs** – Prescription medications used to treat complex, chronic, and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered. These medications are usually required to be filled at a specific pharmacy.
- » **Prior Authorization** – A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- » **Step Therapy** – The goal of a Step Therapy Program is to guide employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The R&C amount is sometimes used to determine the allowed amount. Also known as the UCR (Usual, Customary, and Reasonable) amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, you are provided with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) – The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.



Required Notices

Important Notice From Critical Mass Studios, Inc. dba Rightsline About Your Prescription Drug Coverage and Medicare Under the Cigna Plan(s)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Critical Mass Studios, Inc. dba Rightsline 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. Critical Mass Studios, Inc. dba Rightsline has determined that the prescription drug coverage offered by the Cigna plan(s) 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 Critical Mass Studios, Inc. dba Rightsline coverage may 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 coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Critical Mass Studios, Inc. dba Rightsline 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 at the end of these notices 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 Critical Mass Studios, Inc. dba Rightsline 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 Medicare Part D 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 1, 2026
Name of Entity/Sender:	Critical Mass Studios, Inc. dba Rightsline
Contact—Position/Office:	People Success Team
Address:	214 Main St #376 El Segundo, CA 90245
Phone Number:	866-500-7357 ext. 1015

Women's Health and 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 this plan. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact People Success Team at 866-500-7357 ext. 1015.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact People Success Team at 866-500-7357 ext. 1015.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later 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 towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- » Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- » Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- » Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- » Failing to return from an FMLA leave of absence; and
- » Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 31 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact People Success Team at 866-500-7357 ext. 1015.

30 Important Contacts

Medical

Cigna
866-494-2111
www.mycigna.com

Dental

Cigna
866-494-2111
www.mycigna.com

Vision

EyeMed
866-800-5457
www.eyemed.com

Health Savings & Flexible Spending Accounts

Lively
888-576-4837
www.livelyme.com

Life and AD&D

New York Life
888-842-4462
www.myNYLGBS.com

Disability

New York Life
888-842-4462
www.myNYLGBS.com

Employee Assistance Program

Guidance Resources
800-344-9752
www.guidanceresources.com
Policy #: NYLGBS

Travel Assistance

New York Life
888-226-4567

Rightsline People Success Team

214 Main Street, #376
El Segundo, CA 90245
866-500-7357, ext. 1015





rightsline™