2022 Benefits Guide

ALLIED WORLD
A FAIRFAX Company

At Allied World, nothing is more important than your overall sense of well-being. Our comprehensive suite of benefits supports every aspect of your health and wellness, and we urge you to take advantage of the broad range of available features.

Read on for all the details you need to make your benefits selections.

What's in this guide?

Benefit Basics	3
Cigna Virtual Care	5
Medical Benefits	7
Prescription Drug Coverage	8
Health Savings Account (HSA)	10
Cigna Website & Tools	12
Cigna Easy Choice Tool w/ One Guide	13
Other Cigna Programs	14
Dental Plan	16
Vision Plan	17
Life and Disability Benefits	18
Flexible Spending & Commuter Benefits	19
Employee Assistance Program (EAP)	20
Other Perks	21
PTO and Payroll	22
Employee Contributions	23
Important Contacts	24
Required Notices	25

This guide describes the benefit plans available to you as an employee of Allied World Assurance Company. The details of these plans are contained in the official Plan documents, including some insurance contracts. This guide is meant only to cover the major points of each plan. It does not contain all of the details that are included in your Summary Plan Description (SPD) (as described by the Employee Retirement Income Security Act).

BENEFIT BASICS

Allied World is pleased to offer a comprehensive benefits program to its valued employees.

Once you elect your benefits, your plan elections will remain in place until the end of the plan year, December 31, 2022. You may only change coverage due to a "Qualifying Life Event," and must do so within 31 days of the event. Allied World encourages you to review all your benefits and make your selections wisely.

Eligibility

All full-time active employees working at least 28 hours per week are eligible to enroll in the Allied World benefit programs. Your children may be covered to age 27 regardless of whether they depend on you for support, live with you, are students or are married (medical, dental and vision plans).

Benefits include:

- Medical
- HSA
- Dental
- Vision
- Basic Life, AD&D & Supplemental Life
- Short-Term Disability
- Long-Term Disability
- Flexible Spending Accounts (Dependent Care & Health Care)
- Commuter Benefit Plan
- Traditional & Roth 401(k)

Eligible dependents may include:

- Your spouse
- Your domestic partner (for medical benefits only)
- Your children:
  - Up to age 27 – Medical, Dental and Vision Plans
  - 27 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 the plan or another plan with no break in coverage.

FYI

DID YOU KNOW?

The Allied World Benefit Plan is designed to:

- **Provide competitive and comprehensive benefits**
- **Create a program that considers individual needs**
- **Offer plans which provide financial security**

Changes After Enrollment

If you experience a Qualifying Life Event, you must contact Human Resources within 31 days of the qualifying event.

Some examples of Qualifying Life Events are:

- Marriage
- Birth or adoption of child
- Dependent satisfies or ceases to satisfy eligibility requirements
- Dependent employer's open enrollment
- HIPAA special enrollment rights
- Changes due to a judgment, decree or court order
- Entitlement to Medicare or Medicaid

Your Benefits and Costs

Allied World provides a wide selection of benefits that help protect your health, financial security, and well-being. The company provides some benefits at no cost to you, while other benefits require a shared cost. The design of our benefits program provides you with plan options that best fit your needs and lifestyle. The table below highlights which benefits are provided by Allied World and which benefits are available to you on a contribution basis.

Benefit	Who Pays?	Deduction Status
Medical	Allied World & You	Pre-tax
Dental	Allied World & You	Pre-tax
Vision	You	Pre-tax
HSA	Allied World & You	Pre-tax
Basic Life and AD&D	Allied World	Company Paid Benefit
Supplemental Life	You	Post-tax
Short Term Disability	Allied World	Company Paid Benefit
Long Term Disability	Allied World	Company Paid Benefit
FSA/ Transit Options	You	Pre-tax
Traditional and ROTH 401k	Allied World & You	Pre-tax/Post-tax

Cigna Virtual Care
24/7 Access to a Doctor

Provides immediate, on-demand 24/7/365 access to affordable, quality non-urgent care through a national network of licensed, board-certified doctors, including pediatricians via secure video chat or phone. Cigna utilizes the MDLIVE network.

How it Works

REGISTER ONLINE

If you have not done so already, you will need to register online with **mycigna.com**.

If you are registered, simply log into the **mycigna.com** portal or myCigna mobile app to access Virtual Care.

SEE A DOCTOR VIA PHONE

- **Call toll-free -** Patient calls toll-free hotline available 24/7/365 including holidays: 888.726.3171.
- **Speak with a coordinator -** A consultation coordinator locates the next available doctor and prepares patient for the consultation.
- **Speak with the doctor -** Once an available doctor is located, the system automatically calls and connects the doctor to the patient vs. others.

SEE A DOCTOR VIA VIDEO CONFERENCE

- **Visit myCigna.com or use the myCigna mobile app -** Access the Virtual Care portal by clicking on "Talk to a Doctor or Nurse 24/7 - Connect Now."
- **Find a doctor -** System helps the patient search for a doctor by a criteria, such as specialty, language, gender, location, or simply finds the next available doctor.
- **See the doctor online -** Once an available doctor is located, the system automatically connects the doctor to the patient.

How much does it cost?

- **Standard Plan:** $25 copay
- **HDHP Plan:** cost share is based on the network contracted rate and will apply to the deductible, subject to coinsurance after deductible is met
- Virtual wellness screenings and the associated labs for your visit are covered at NO COST to you, as part of your preventive care benefits

Covered Conditions Include:

- Acne
- Allergies
- Cold and Flu
- Fever
- Headaches
- Pink Eye
- Rashes
- Sore Throat
- Sunburn
- Urinary Tract Infection
- Behavioral/ mental health

FYI

WHAT HAPPENS AFTER THE VISIT?

- **Email Communication -** Patient can elect for consultation history to be sent to personal doctor.
- **Prescription Services -** MDLIVE doctors may prescribe medication when appropriate and send the prescription directly to your pharmacy.

Virtual Wellness Screenings through MDLIVE

Simply make your appointment online and go for a quick visit to a lab for your blood work. The rest is completed online and via video or phone, wherever it's most convenient for you.

STEP 1

Complete your MDLIVE online health assessment.

STEP 2

Choose an in-network lab and schedule an appointment.

STEP 3

Choose an MDLIVE provider and schedule your virtual visit.

STEP 4

Go to your lab appointment. You will receive a notification when the results are available in the MDLIVE customer portal.

STEP 5

Attend your virtual visit from anywhere via video or phone. You will receive a summary of your screening results for your records.

GET STARTED

Get started with your virtual wellness screening by visiting **mycigna.com** and choosing the **"Talk with a doctor or nurse 24/7"** callout box and clicking **"Connect Now."**

Virtual wellness screenings are covered at 100% under the OAP and HDHP plans.

Medical Benefits
On the Road to Wellness

In 2022, Allied World will continue to offer the same two medical plans, the **Standard Plan** and the **High Deductible Health Plan (HDHP)**. This gives employees the flexibility to choose a medical plan that suits their needs and the needs of their family. **Both plans provide 100% coverage for preventive care for you and your family.**

	Standard Plan		HDHP	
Medical	You Pay In-Network	You Pay Out-of-Network	You Pay In-Network	You Pay Out-of-Network
Deductible[1] Employee / Family	$500 / $1,000	$1,000 / $2,000	$1,500 / $3,000	$3,000 / $6,000
Coinsurance	20%	40%	20%	40%
Out-of-Pocket Maximum[2] Employee / Family	$4,000 / $8,000	$8,000 / $16,000	$3,000 / $6,000	$6,000 / $12,000
Preventive Care	Fully Covered	40% after deductible	Fully Covered	40% after deductible
Primary Care Physician	$25	40% after deductible	20% after deductible	40% after deductible
Specialist Visit	$40	40% after deductible	20% after deductible	40% after deductible
Inpatient Hospital	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Lab and X-Ray	No Charge (after office copay)	40% after deductible	20% after deductible	40% after deductible
Emergency Room	$150	$150	20% after deductible	20% after deductible
Urgent Care	$25 copay	$25 copay	20% after deductible	40% after deductible
Prescription[3]				
Retail (30-Day Supply)				
Tier 1	$5	30% after deductible	$5 after deductible	30% after deductible
Tier 2	$25		$25 after deductible	
Tier 3	$40		$40 after deductible	
Cigna 90 Now or Mail Order (90-Day Supply)				
Tier 1	$10	30% after deductible	$10 after deductible	30% after deductible
Tier 2	$63		$63 after deductible	
Tier 3	$100		$100 after deductible	

1. Copays do not apply to the deductible
2. Includes deductible
3. Prescription Drug plan will include Step Therapy, quantity limits and prior authorization

FYI

Enhanced Care Management Program

The enhanced program includes additional support for outpatient discharge, accessing community resources and programs, and arrangements for care.

Prescription Drug Coverage

Cost-effective pharmacy benefit

Your plan is designed to provide you with quality health care coverage, and that includes a cost-effective pharmacy benefit. Certain medications on your drug list have extra requirements before your plan will cover them. This helps to make sure you're receiving coverage for the right medication, at the right cost, in the right amount and for the right situation.

Medications that need approval for coverage

Certain medications need approval from Cigna before your plan will cover them. These medications have a (PA) next to them on your drug list.

WHAT TYPES OF MEDICATIONS TYPICALLY NEED APPROVAL?

Medications that:

- May be unsafe when combined with other medications
- Have lower-cost, equally effective alternatives available
- Should only be used for certain health conditions
- Are often misused or abused

Your plan will only cover these medications if your doctor's office requests and receives approval from Cigna.

Medications that have quantity limits

For some medications, your plan only covers up to a certain amount over a certain length of time. For example, your plan may only cover 30 mg a day for 30 days of a certain medication. These medications have a (QL) next to them on your drug list.

WHAT TYPES OF MEDICATIONS TYPICALLY HAVE QUANTITY LIMITS?

Medications that are often:

- Taken in amounts larger than, or for longer than, may be appropriate
- Misused or abused

Your plan will only cover a larger amount if your doctor's office requests and receives approval from Cigna.

Medications that are part of Step Therapy

Certain high-cost medications are part of the Step Therapy program.[1] These medications have a (ST) next to them on your drug list. Step Therapy encourages the use of lower-cost medications (typically generics and preferred brands) that can be used to treat the same condition as the higher-cost medication. Your plan doesn't cover the higher-cost Step Therapy medication until you try one or more alternatives first (unless you receive approval from Cigna).[2]

1. Due to state mandates, Step Therapy requirements may vary or may not apply to your specific health plan. To find out if these state mandates apply to your plan, review your plan materials or contact Cigna Customer Service at the number listed on your ID card.

2. If your doctor feels an alternative medication isn't right for you, he or she can ask Cigna to consider approving coverage of your current medication.

Cigna 90 Now

Your plan includes a maintenance medication program called Cigna 90 Now. Maintenance medications are taken regularly, over time, to treat an ongoing health condition. Cigna 90 Now offers you more choice in how, and where, you can fill your prescription.

- **90-day supply:** If you choose to fill your prescription in a 90-day supply, you have to use a 90-day retail pharmacy in your plan's new network, or Cigna Home Delivery Pharmacy℠.
- **30-day supply:** If you choose to fill your prescription in a 30-day supply, you can use any retail pharmacy in your plan's new network.

For more information about your pharmacy network, you can go to **myCigna.com** or the myCigna app.

FYI

Important Changes to Your Cigna Pharmacy Plan for 2022

Your Cigna pharmacy plan is changing drug lists. Starting January 1, 2022, you will use the Value Prescription Drug List. This is a list of the prescription medications your plan covers.

Things to know about the Value Prescription Drug List:

- Includes more generic and lower-cost brand medications. Generic medications offer the same strength and active ingredients as the brand-name but often cost much less.
- Brand medications may fall into a different cost-share tier.
- Certain high-cost brand medications are excluded because they have lower-cost alternatives which are used to treat the same condition. Meaning, the alternative works the same or similar to the non-covered medication. If you're taking a medication that your plan doesn't cover and your doctor fees an alternative isn't right for you, he or she can ask Cigna to approve the coverage.
- Excludes certain prescription medications from coverage.

How your plan covers certain medications with over-the-counter (OTC) alternatives

Your plan covers generic prescription medications that are used to treat allergies and heartburn/stomach acid conditions. These medications have OTC alternatives, which are available without a prescription.

Allergy Medications (non-sedating antihistamines)	Heartburn/Stomach Acid Conditions
citirizine desloratadine fexofenadine levocetirizine	esomeprazole lansoprazole omeprazole pantoprazole rabeprazole

Compare your medication costs

You should talk with your doctor about your options. An OTC medicine may cost you less out-of-pocket than the prescription version. If you decide to fill a prescription medication, log into the MyCigna app or website to compare your costs. Simply click on a "Price a Medication" to see how much your medication may cost you at the different pharmacies in your plan's network.

Health Savings Account (HSA)

Take Charge of Your Healthcare

Take charge of your healthcare spending with a health savings account (HSA), which works alongside the **HDHP**. An HSA is a personal healthcare bank account that you can use to pay out-of-pocket health expenses with pre-tax dollars.

HSA Overview

The contributions made to your HSA are tax-free, and the money remains in the account for you to spend on eligible expenses, no matter where you work or how long it stays in the account. HSAs allow you to control your own money, year in and year out.

You are eligible to open and fund an HSA if:

- You are covered by an HSA-eligible high-deductible health plan (like the **HDHP**).
- You are not covered by another medical plan or your spouse's health care flexible spending account or a health reimbursement arrangement (HRA).
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE for Life.
- You are not receiving Social Security benefits.
- You have not received Veterans Administration benefits.

Individuals age 55 or older may make an additional $1,000 annual contribution to their HSA.

Your HSA account can be used for your expenses and those of your spouse and dependents (excluding domestic partners), even if they are not covered by the HDHP. Eligible expenses include doctor's office visits, eye exams, prescription expenses, and LASIK surgery. IRS Publication 502 provides a complete list of eligible expenses and can be found at irs.gov.

FYI

Employer Contributions

Employees who elect the **HDHP** will have the opportunity to contribute a portion of their paycheck, tax-free, into an HSA.

The company will also contribute to your HSA if you open an account with HSA Bank. The table below outlines the contributions for different levels of coverage:

	HDHP
	Allied World Contribution
Employee Only	$1,000
All Other Tiers	$1,500

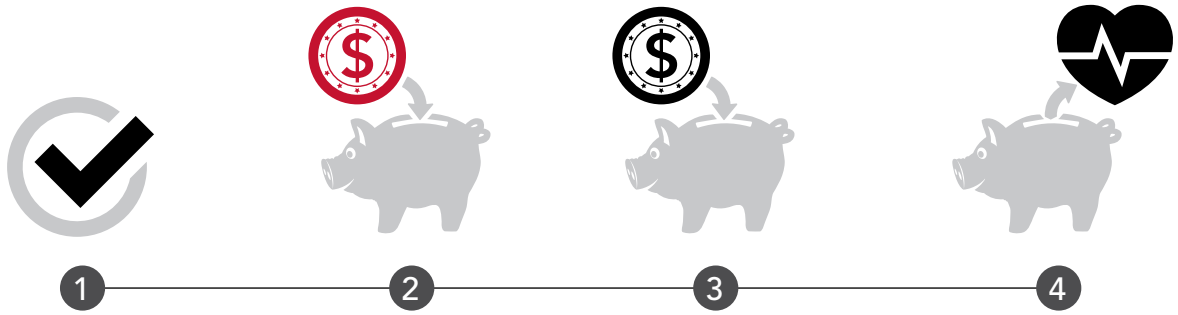
HSA Funding and Limits

The 2022 IRS maximum contributions, including employer contributions for these accounts, are:

- Employee only — $3,650
- All other tiers — $7,300
- HSA Catch-Up (Age 55 or older) — $1,000

The total of your 2022 pre-tax contributions and Allied World's contributions combined cannot exceed the IRS maximum. **You are responsible for keeping track of all contributions to ensure your account does not exceed the IRS limit.**

How does the HSA work?



1. Enroll in the HDHP.
2. Allied World contributes money in your HSA.
3. You save money in your HSA.
4. Use the HSA to pay for eligible medical expenses or save for the future.

Every little bit counts, and adds up quickly...

If you save:	Balance in 5 yrs	Balance in 10 yrs	Balance in 15 yrs
$50 per month	$3,000	$6,000	$9,000
$100 per month	$6,000	$12,000	$18,000
$250 per month	$15,000	$30,000	$45,000

Save up to 30% on taxes!

$100 without an HSA

$70 in your pocket | **$30 in taxes**

$100 with an HSA

$100 IN YOUR POCKET

NO TAXES!

Who can you use your HSA for?

You, your spouse, and dependent children...even if they're not covered by your health plan, can use your HSA to pay for qualified medical expenses.

You Own Your HSA

It goes where you go and carries over each year.

Save For the Future

Not many accounts allow you to make tax-free contributions and tax-free withdrawals—and enjoy tax-free growth. So why not use your HSA to help maximize your potential to save for your future?

Cigna Website and Tools
Easy to Register and Easy to Use!

Nothing is more important than your good health. That's why there is myCigna.com — your online home for assessment tools, plan management, medical updates, and more. The website can also be used to answer a variety of questions that you may have about your benefits. You and your dependents can access this website from home or on-the-go using your smart phone or other mobile device.

Why should I register?

When you create an account with myCigna.com, you will be able to:

- Get answers to coverage questions
- Track claims activity and claims status
- Find a provider
- Manage your profile
- Print Temporary ID cards
- Complete your voluntary online Health Risk Assessment
- Research a variety of health and wellness related topics to make the best possible decisions
- Manage your health plan whenever and wherever you like
- Estimate healthcare costs and save on out-of-pocket expenses - Visit myCigna.com, log in and click on "Provider Search Tool"
- Learn how to live a healthier life

myCigna Mobile App

The **myCigna Mobile App** gives you an easy way to organize and access your important health information. Download the app today in your app store.

- Find a doctor, dentist or healthcare facility
- View ID card information for the entire family
- Review deductibles, account balances and claims

FYI

HOW TO REGISTER

1. **Go to myCigna.com and select "Register."**
2. **Enter your personal details like name, address and date of birth.**
3. **Confirm your identity with secure information like your Cigna ID, social security number or a security question. This will make sure only you can access your information.**
4. **Create a user ID and password.**
5. **Review and submit.**

Please Note: If you are covered by another family member's Cigna plan, you may need to enter the Primary Customer's social security number or Cigna ID.

Choose a Plan With Confidence

Whether you're a current Cigna customer or considering Cigna for the first time, we understand how confusing and overwhelming it can be to review your health plan options. And we want to help by providing the resources you need to make a decision with confidence. That's why Cigna Easy Choice Tool with One Guide is available to you now.

Cigna Easy Choice Tool

Cigna Easy Choice Tool helps you choose the health plan that's right for you:

- Answer a few questions about what you want in a plan
- Based on your answers, we'll present the plans starting with your Best Fit, Next Best Fit, and so on
- Compare plans side-by-side to view costs, doctors and networks
- Create an Enrollment Checklist of your favorite plans
- Take the checklist with you when you enroll in your benefits

COMPARE PLANS TODAY

Access Cigna Easy Choice Tool by visiting **bit.ly/3681Xl6** and entering your employee access code:

All Employees <$50k
4DHT3PH3

All Employees $50k – <$100k
PH3HVDEK

All Employees $100k – <$250k
U94FYNLL

All Employees $250k+
AUKKHX9U

Cigna One Guide

PRE-ENROLLMENT

Call a Cigna One Guide representative during pre-enrollment to get personalized, useful guidance. Your personal guide will help you:

- Easily understand the basics of health coverage
- Identify the types of health plans available to you that best meet the needs of you and your family
- Check if your doctors are in-network to help you avoid unnecessary costs
- Get answers on any other questions you may have about the plans or provider networks available to you

The best part is, during the enrollment period, your personal guide is just a call away.

AFTER ENROLLMENT

After enrollment, the support continues for Cigna customers.

Your Cigna One Guide representative will be there to guide you through the complexities of the health care system, and help you avoid costly missteps. Cigna One Guide service provides personalized assistance to help you:

- Resolve health care issues
- Save time and money
- Get the most out of your plan
- Find the right hospitals, dentists and other health care providers in your plan's network
- Get cost estimates and avoid surprise expenses
- Understand your bills

FYI

Don't wait until the last minute to enroll.
Call 888-806-5042 to speak with a Cigna One Guide representative today.[1]

1. During enrollment, personal guides available Monday through Friday, 8:00 am–9:00 pm EST. Once your coverage begins, call the number on your ID card to speak with a personal guide. Additional customer service representatives are available 24/7.

Other Cigna Programs
Designed For You

Cigna Lifestyle Management Programs

Whether your goal is to lose weight, quit tobacco or lower your stress levels, you have the power to make it happen. Cigna Lifestyle Management Programs can help – and all at no added cost to you. Each program is easy to use and available where and when you need it. And, you can use each program online or over the phone – or both.

- **Weight management:** Create a personal healthy-living plan that will help you build your confidence, be more active and eat healthier.
- **Tobacco:** Create a personal quit plan with a realistic quit date. And, get the support you need to kick the habit for good.
- **Stress management:** Learn what causes you stress in your life and develop a personal stress management plan.

ENROLL TODAY

To enroll in the program, or if you have questions, call 866.417.7848.

Or, if you want to enroll online, visit **mycigna.com**, select "My Health" tab, then "Programs and Resources," then select "Health Assistant" from the drop-down menu.

NEW FOR 2022!

Omada Diabetes Prevention Program

Omada is a digital lifestyle change program that combines the latest technology with ongoing support so you can make the changes that matter most – whether that's around eating, activity, sleep, or stress. It's an approach shown to help you lose weight and reduce the risks of type 2 diabetes and heart disease.

- **Eat Healthier** – learn the fundamentals of making smart food choices.
- **Increase Activity** – discover easy ways to move more and boost your energy.
- **Overcome Challenges** – gain skills that allow you to break barriers to change.
- **Strengthen Habits** – zero in on what works for you and find lasting motivation.
- **Stay Healthy for Life** – continue to set and reach your goals with strategies and support.

GET STARTED

This program is available at no additional cost if you or your adult dependents (spouse/domestic partner or child age 18+) are enrolled in the Allied World medical plan and are at risk for diabetes or heart disease and are accepted into the program.

Visit **go.omadahealth.com/alliedworld** to see if you're eligible.

Cigna Healthy Rewards

Ready to work out? As a Cigna customer, you have access to a bunch of discounts on health programs and services, including gym memberships, through the Cigna Healthy Rewards® program.

SIGN UP TODAY

Start by logging in to **myCigna.com** and then:

1. Go to "Wellness" tab on the top right of your screen
2. Go to "Stay Healthy" > "Healthy Rewards - Discount Programs"
3. Find the blue tab > "Fitness & Mind/Body"
4. Scroll down > "Fitness Discounts" > "Low-cost Fitness Center Memberships" > "Learn More"

FIND A LOCAL GYM

From here the Active&Fit Direct™ page takes the heavy lifting out of finding a local gym and accessing your discounted membership – only $25 per month![1]

From the home page, you can find a local gym by your zip code or city/state and get details on the facility. If you're ready to get your discounted membership, just click "Enroll Now."

Not ready to enroll? Click "Request Guest Pass Letter" in your search results, create an account and then print your guest pass.

1. Plus a $25 one-time enrollment fee and applicable taxes

Cigna Healthy Pregnancies

Enrolling in the Cigna Healthy Pregnancies, Healthy Babies® program is an important first step toward a healthy future for you and your baby. They help you stay healthy before and during your pregnancy and in the days and weeks following your baby's birth.

Call 800-615-2906 to enroll today.

GET REWARDED

When you participate and complete the program you will receive:

- A $75 incentive if you enroll by the end of your second trimester and complete the postpartum assessment; or
- A $150 incentive if you enroll by the end of your first trimester and complete the postpartum assessment.

Dental Benefits

Keeping You Healthy

Taking care of your teeth is an important part of your overall health. That is why Allied World offers a dental plan that covers routine check-ups and additional services needed for your health. With the PPO plan, you receive benefits whether or not you and/or a dependent visit a participating dentist. You can maximize your benefits and lower your out-of-pocket costs by choosing a doctor in-network. A preventive incentive program is in place that increases the annual maximum by $100, if you have diagnostic and preventive services done.

Dental	PPO Plan	
	In-Network	Out-of-Network
Deductible Employee / Family	$50 / $150	
Annual Benefit Maximum	$1,000	
Preventive Services	100% (No Deductible)	100% of Reasonable & Customary Charge (No Deductible)
Basic Services	80% after deductible	80% of Reasonable & Customary Charge (No Deductible)
Major Services	50% after deductible	50% of Reasonable & Customary Charge (No Deductible)
Orthodontia	50%	
Lifetime Orthodontia Max	$1,000	

FYI

NEED TO FIND A DENTIST?

Visit cigna.com or call (800) 997-1654 to learn more.

Vision Benefits

Cost Effective Peace of Mind

Allied World provides you with vision benefits through VSP. Choosing a vision provider in-network is a cost effective way to take advantage of the savings on exams, frames, lenses, and contacts. If you already have a vision provider that you would like to use, but is out-of-network, there are also savings available. These savings will not be as much as in-network, but they will help lower your out-of-pocket costs.

Vision	VSP Vision Plan	
	In-Network	Out-of-Network
Deductible Per Person	$20	$20
Vision Exam	Covered in Full[1]	Up to $50[1]
Contact Lens Exam Fitting and Evaluation	Up to $60[1]	
Frames	Covered up to Plan Allowance[1]	Up to $70[1]
Lenses Single Vision Lined Bifocal Lined Trifocal Lenticular	Covered in Full[1]	Up to $50[1] Up to $75[1] Up to $100[1] Up to $75[1]
Contact Lenses Elective Necessary	$130 allowance for contacts	Up to $105[1] Up to $210[1]
Frequency Exam Lenses Frames	Every 12 months Every 12 months Every 24 months	

1. Less any applicable copays

FYI

FIND THE RIGHT EYE DOCTOR

The VSP network includes:
Costco, Visionworks®, RxOptical®, Pearle Vision, Cohen's Fashion Optical, Walmart and Sam's Club.

Visit vsp.com or call (800) 877-7195 to learn more.

Life & Disability Benefits
Always There For You

Allied World provides Basic and Supplemental Life, Accidental Death and Dismemberment, Short Term Disability, and Long Term Disability insurance to its employees through Prudential. The benefits through this plan are illustrated below:

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

- 2 x Annual Earnings to a maximum of $1,000,000.
- Guaranteed Limit up to $750,000.

Short-term Disability Insurance:

- Weekly benefit is 60% of weekly earnings to a maximum benefit of $2,500 per week.
- Benefits begin on the 8th day of injury or illness.
- Maximum payment period: 26 weeks.
- Gross-up: You will be required to pay taxes on the premium, but the benefit will not be taxed.

Long-term Disability Insurance:

- Covers 60% of monthly earnings.
- Monthly maximum benefit up to $15,000.
- Benefits begin after 180 days of disability.
- Gross-up: You will be required to pay taxes on the premium, but the benefit will not be taxed.

Supplemental Life Insurance:

- Individual: Up to 6 times annual earnings in increments of $10,000 to a maximum of $1,000,000.
- Spouse: Can be elected in units of $5,000 to a maximum of $250,000. Cannot exceed 50% of employee benefit.
- Dependent Children: Flat $10,000. Maximum benefit for a dependent child who is less than 6 months old is $500.
- Employee must elect coverage for self in order to elect for spouse/dependents.

FYI

LOOKING FOR MORE INFORMATION?

Visit Prudential.com or call (800) 778-2255 to learn more.

Supplemental Voluntary Life Insurance Rates (Per month per $1,000 of coverage)		
Age	Employee	Spouse
Under 25	$0.060	$0.060
25-29	0.060	0.060
30-34	0.080	0.080
35-39	0.090	0.090
40-44	0.100	0.100
45-49	0.150	0.150
50-54	0.230	0.230
55-59	0.430	0.430
60-64	0.660	0.660
65-69	1.270	1.270
70-74	2.060	2.060
75-99	6.035	6.035
Child Rate	$2.00 per month for coverage	

Flexible Spending & Commuter Benefits
Pre-Tax Savings

isolved Benefit Services

Flexible Spending Account

Allied World offers employees the option to put money away tax free into a Flexible Spending Account (FSA) for Health Care and Dependent Care expenses.

A Flexible Spending Account works like a savings account – each pay period a pre-tax payroll deduction is deposited to your Health Care and/or Dependent Care Flex Spending Account. You will be given a debit card associated with your Health Care FSA to use at the time of service or when paying bills manually.

Please keep in mind that funds in a Flexible Spending Account are subject to the **"use it or lose it"** rule. This means that you will have until March 15, 2023 to spend down your 2022 funds or any money left over will be forfeited. Make elections carefully and only choose to put away the money you predict you will spend in the upcoming plan year.

Account	Used For	Contributions
Health Care Flexible Spending Account	Most medical, dental, and vision care expenses (like co-payments, deductible, coinsurance, eyeglasses)	$2,850 annual maximum
Dependent Care Reimbursement Account	Dependent care expenses (day care, after-school programs, or elder care programs) so you and your spouse can work or go to school full-time	$5,000 annual maximum (per household) Up to $2,500 annual maximum (if married, but filing separate return)

Commuter Benefit Plan

The iSolved Benefit Services Commuter Benefit Plan provides you with the convenience and tax savings for doing what you already do – commute to and from work. You can deduct up to $280 per month to pay for mass transit and $280 per month to pay for parking costs on a pre-tax basis.

Please note: Transit amounts may only be spent on transit and parking amounts may only be spent on eligible parking.

FYI

LOOKING FOR MORE INFORMATION?

Visit isolvedbenefitservices.com or call (800) 300-3838 to learn more.

Remember - You must re-enroll for the health care and dependent care FSA programs on an annual basis.

Employee Assistance Program

ComPsych® — The GuidanceResources Company®

Personal problems, planning for life events or simply managing daily life can affect your work, health and family. GuidanceResources is a company-sponsored service that is available to you and your dependents, at no cost, to provide confidential support, resources and information to get through life's challenges.

Confidential Counseling

The EAP is staffed by experienced clinicians and is available by phone 24 hours a day, seven days a week. A GuidanceConsultant℠ is available to listen to your concerns and refer you to a local provider for in-person counseling or to resources in your community. Call any time with personal concerns, including:

- Depression
- Stress and anxiety
- Marital and family conflicts
- Alcohol and drug abuse
- Job pressures
- Grief and loss

Additional Resources

Financial issues can arise at any time, from dealing with debt to saving for college. Financial professionals are available to discuss your concerns and provide you with the tools and information you need to address your finances.

When a legal issue arises, attorneys are available to provide confidential support with practical, understandable information and assistance. If you require representation, you can also be referred to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter.

Online Tools and Services

GuidanceResources® Online is your one stop for expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial concerns. Create your own account by going to guidanceresources.com.

Identity Theft Services

IDResources include:

- Assistance navigating the identity restoration process
- Notifying creditors and banks
- Contacting police departments to ensure that police reports are filed
- Ensuring identity theft affidavits are complete and submitted to credit card companies and credit reporting agencies

IDResources professionals understand the complex legal, financial, emotional and work-life issues that accompany identity theft.

Their integrated services help victims and their families cope with the prolonged effects of identity theft through:

- Counseling to address emotional issues
- Financial information from staff CPAs or CFPs to address credit issues
- Assistance with work-life needs

FYI

CONTACT THE EAP 24/7

Call: 800.311.4327
TDD: 800.697.0353
Online: guidanceresources.com
Your company Web ID: GEN311

Other Perks

401(k)

- **Eligibility:** Eligible day 1 of employment – enroll online in Oracle HRIS
  - Must be 21 years old to participate
- **Company Match:** up to 6% (dollar for dollar)
  - Vested at 100% from the day you enter plan
- **2022 Federal Max:** $20,500
  - Note: $20,500 is the IRS maximum limit that you contribute to retirement plan in 1 year, regardless of how many employers you had that year. Please be sure to consider contributions with previous employers when you decide on your AW contribution.
- **Age 50 & Over Catch Up Contribution:** $6,500 (for anyone who turns 50 at any time during the year)
- Employees can change % at any time through the Oracle HRIS system
- Employees may roll over 401(k) from previous employers – contact HR

Referral Bonus

- Referral bonuses are awarded to employees who referred a candidate that was hired and stayed with the company for at least 6 months
  - If the position hired for is non-exempt, the bonus is $1,000
  - If the position hired for is exempt, the bonus is $2,000
- All employees except VP and above, HR and managers with hiring authority over the referred candidates are eligible for this bonus

FYI

UPDATE YOUR CONTRIBUTIONS

After your first paycheck, visit pensions123.com to choose your fund allocations. Until then, all 401(k) elections will default to the Balanced Fund- Invesco Equity and Income Investment Option.

First Time Logging In?

- **Your username is your Social Security Number (no dashes)**
- **Your password is the last 6 digits of your SSN followed by your first and last initials.**

Tuition Reimbursement

- For job related courses
- After you've been here for 6 months and are in good standing
- See Human Resources for more information

ESPP – Employee Share Purchase Plan

- Employees may contribute 1-10% of base salary through bi-weekly post-tax payroll deductions
- Shares are purchased bi-weekly and held in an account with Computershare
- 30% company match per pay period (also taxed)
- 20% company match at year end if company meets its financial targets
- Changes may be made to your election once per month or cancel at any time
- New hires must wait 6 months after hire date to enroll

PTO and Payroll

Paid Time Off

Paid Time Off (PTO) days provide pay for absences including vacation, personal and sick time. The number of days allotted for PTO is based on calendar years worked and you earn days on a monthly basis; however, the full allotment of PTO days is available for use upon the start of each calendar year. Full-time employees are entitled to PTO each calendar year in accordance with the following schedule:

- **In the 1st – 5th calendar years of service:** 23 days
- **In the 6th – 9th calendar years of service:** 25 days
- **In the 10th – 15th calendar years of service:** 30 days
- **In the 15th and subsequent calendar years of service:** 35 days

Up to five unused PTO days may be carried forward into the next year. Anything in excess of this will be forfeited at year's end unless otherwise prohibited by law.

Individuals hired any time after January 1 will be entitled to a pro-rated portion of the entitlement for such year. Employees who are not benefits eligible because they work less than 28 hours per week will receive five PTO days per year based on their standard work hours.

Exempt employees (i.e., those not eligible for overtime pay) may take PTO in increments of half-days or full days and will record their time in eDays. Non-exempt employees may take PTO in hourly increments and record their time in eTime.

Payroll

- Bi Weekly Payroll - Paid every other Thursday
- Paychecks mailed to each office, distributed by office administrator if receiving a live paycheck
- Direct Deposit – option to split between multiple accounts
  - Direct Deposit form located on the New Employee Orientation site
  - Takes 1 pay period to kick in; first check is a live check
  - No stubs will be issued - all stubs need to be obtained through the ADP iPay site
  - Once you receive your first paycheck, you will be able to access the ADP iPay site

Employee Contributions

Your Contribution to Benefits

The following bi-weekly contributions are effective January 1, 2022:

Medical Plan	Standard Plan	HDHP Plan
< $50k		
Employee Only	$27.30	$5.81
Employee + Spouse	$56.17	$12.03
Employee + Domestic Partner	$56.17	$12.03
Employee + Child(ren)	$45.61	$9.75
Employee + Domestic Partner + Children	$80.03	$17.16
Employee + Family	$80.03	$17.16
$50k - <$100k		
Employee Only	$43.70	$20.71
Employee + Spouse	$89.88	$42.66
Employee + Domestic Partner	$89.88	$42.66
Employee + Child(ren)	$72.99	$34.63
Employee + Domestic Partner + Children	$128.48	$61.22
Employee + Family	$128.48	$61.22
$100k - <$250k		
Employee Only	$95.59	$48.86
Employee + Spouse	$196.59	$100.64
Employee + Domestic Partner	$196.59	$100.64
Employee + Child(ren)	$159.66	$81.71
Employee + Domestic Partner + Children	$280.09	$143.46
Employee + Family	$280.09	$143.46
$250k+		
Employee Only	$142.03	$91.08
Employee + Spouse	$292.10	$187.46
Employee + Domestic Partner	$292.10	$187.46
Employee + Child(ren)	$237.19	$152.20
Employee + Domestic Partner + Children	$416.11	$267.12
Employee + Family	$416.11	$267.12

Dental Plan	CIGNA Dental Plan
Employee Only	$4.75
Employee + Spouse	$10.00
Employee + Child(ren)	$10.00
Employee + Family	$14.00

Vision Plan	VSP Vision Plan
Employee Only	$3.95
Employee + Spouse	$6.32
Employee + Child(ren)	$6.46
Employee + Family	$10.41

Important Contacts

Need additional information? Have a question about one of your benefits? Keep this brochure handy for a quick reference for all your benefit needs. Listed below are the carrier contacts for your reference. If you still have questions, please contact Human Resources.

Plan	Administrator	Website	Phone
Medical Benefits	Cigna	mycigna.com	1-800-997-1654
Cigna Telehealth Connection	MDLIVE	mdliveforcigna.com	1-888-726-3171
Health Savings Account	HSA Bank	hsabank.com	1-800-357-6246
Dental Benefits	Cigna	mycigna.com	1-800-997-1654
Vision Benefits	VSP	vsp.com	1-800-877-7195
Life and AD&D Plan	Prudential	prudential.com	1-800-778-2255
Supplemental Life Plan			
Short Term Disability			
Long Term Disability			
Employee Assistance Program	ComPsych	guidanceresources.com Web ID: GEN311	1-800-311-4327
FSA	iSolved Benefit Services	isolvedbenefitservices.com	1-800-300-3838
Commuter Benefit			

Required Notices

IMPORTANT NOTICE FROM ALLIED WORLD ASSURANCE COMPANY (U.S.) INC. 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 Allied World Assurance Company (U.S.) Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Allied World Assurance Company (U.S.) Inc. has determined that the prescription drug coverage offered by the Allied World Assurance Company (U.S.) Inc. Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules
As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty
If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
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. See the Allied World Assurance Company (U.S.) Inc. Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Allied World Assurance Company (U.S.) Inc. Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Allied World Assurance Company (U.S.) Inc. Plan 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 below.

If you do decide to join a Medicare drug plan and drop your Allied World Assurance Company (U.S.) Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 860-284-1842. **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 Allied World Assurance Company (U.S.) Inc. changes. You also may request a copy.

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 whether or not you are required to pay a higher premium (a penalty).

Date:	November 4, 2021
Name of Entity/Sender:	David McCauley
Contact—Position/Office:	Executive Vice President Global Head of Human Resources Group
Address:	Suite 1600 – 200 King Street West Toronto, Ontario M5H 3T4
Phone Number:	646.974.0553

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

ALLIED WORLD ASSURANCE COMPANY (U.S.) INC.
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you on behalf of:

Allied World Assurance Company (U.S.) Inc. Health and Welfare Program

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Allied World Assurance Company (U.S.) Inc. that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information

The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**
  - **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
  - **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Allied World Assurance Company (U.S.) Inc.) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and

disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.

- **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
- **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny

the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.

- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach

Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint

If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

David McCauley
Executive Vice President
Global Head of Human Resources Group
646.794.0553

Effective Date

The effective date of this notice is: November 4, 2021.

ALLIED WORLD ASSURANCE COMPANY (U.S.) INC. EMPLOYEE HEALTH CARE PLAN
NOTICE OF 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 toward 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 (e.g., 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 eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility 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 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 toward 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:

David McCauley
Executive Vice President
Global Head of Human Resources Group
646.794.0553

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL NOTICE OF COBRA CONTINUATION RIGHTS

You are receiving this Notice of COBRA healthcare coverage continuation rights because you have recently become covered under one or more group health plans. The plan (or plans) under which you have gained coverage are listed at the end of this Form, and are referred to collectively as "the plan" except where otherwise indicated.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of healthcare coverage under the plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and/or to other members of your family who are covered under the plan when you and/or they would otherwise lose the group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. ***This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.*** For more information about your rights and obligations under the plan and under federal law, you should either review the plan's Summary Plan Description or contact the Plan Administrator. In some cases the plan document also serves as the Summary Plan Description.

Note you may have other options available to you when you lose group health coverage. When you become eligible for COBRA, you may also become eligible for other coverage options not provided by your employer that may cost less than COBRA continuation 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.

COBRA Continuation Coverage and "Qualifying Events"
COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and eligible children of employees may be qualified beneficiaries. Certain newborns, newly-adopted children and alternate recipients under qualified medical child support orders may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. Under the plan, qualified beneficiaries who elect COBRA continuation coverage generally must pay for this continuation coverage.

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

❖ Your hours of employment are reduced, or

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment); or
- You become divorced or legally separated from your spouse. Note that if your spouse cancels your coverage in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you actually lost coverage earlier. ***If you notify the Plan Administrator or its designee within 60 days after the divorce or legal separation and can establish that the employee canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for a period after the divorce or legal separation (but not for the period between the date your coverage ended, and the date of divorce or legal separation).*** But you *must* provide timely notice of the divorce or legal separation to the Plan Administrator or its designee or you will not be able to obtain COBRA coverage after the divorce or legal separation. See the rules in the box below, under the heading entitled, *"Notice Requirements,"* regarding the obligation to provide notice, and the procedures for doing so.

Your covered ***eligible children*** will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as an "eligible child."

Notice Requirements

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator or its designee has been ***timely notified*** that a qualifying event has occurred. When the qualifying event is:

- the end of employment or reduction of hours of employment,
- death of the employee,

the employer (if the employer is not the Plan Administrator) must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

IMPORTANT:

For the other qualifying events (divorce or legal separation of the employee and spouse or an eligible child's losing eligibility for coverage as an eligible child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or eligible child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department, or firm listed below, at the following address:

David McCauley
Executive Vice President
Global Head of Human Resources Group
Suite 1600 – 200 King Street West
Toronto, Ontario M5H 3T4
Canada
T: 646.794.0553

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the ***name of the plan or plans*** under which you lost or are losing coverage,

- the ***name and address of the employee*** covered under the plan,
- the ***name(s) and address(es) of the qualified beneficiary(ies)***, and
- the ***qualifying event*** and the ***date*** it happened.

If the qualifying event is a ***divorce or legal separation***, your notice must include ***a copy of the divorce decree or the legal separation agreement***.

There are other notice requirements in other contexts. See, for example, the discussion below under the heading entitled, *"Duration of COBRA Coverage."* That explanation describes other situations where notice from you or the qualified beneficiary is required in order to gain the right to COBRA coverage.

Once the Plan Administrator or its designee receives *timely 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 for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. ***If you or your spouse or eligible children do not elect continuation coverage within the 60-day election period described above, you will lose your right to elect continuation coverage.***

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in any part of Medicare, your divorce or legal separation, or an eligible child losing eligibility as an eligible child, COBRA continuation coverage lasts for up to ***36 months***.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to ***18 months***.

There are *three ways* in which the period of COBRA continuation coverage can be extended…

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

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled as of the date of the qualifying event or at any time during the first 60 days of COBRA continuation coverage ***and you notify the Plan Administrator or its designee in writing and in a timely fashion***, you and your entire family can receive up to ***an additional 11 months*** of COBRA continuation coverage, for a total maximum of ***29 months***.

You must make sure that the Plan Administrator or its designee is notified in writing of the Social Security Administration's determination within 60 days after (i) of the date of the determination or (ii) the date of the qualifying event or (iii) the date coverage is lost due to the qualifying event, whichever occurs last. But in any event the notice must be provided before the end of the 18-month period of COBRA continuation coverage. The plan requires you to follow the procedures specified in the box above, under the heading entitled *"Notice Procedures."* In addition, your notice must include

- the name of the disabled qualified beneficiary,
- the date that the qualified beneficiary became disabled, and
- the date that the Social Security Administration made its determination.

Your notice must also include a copy of the Social Security Administration's determination. ***If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required period, then there will be no disability extension of COBRA continuation coverage.***

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

If your family experiences ***another qualifying event*** while receiving COBRA continuation coverage, the spouse and eligible children in your family can get additional months of COBRA continuation coverage, up to a maximum of ***36 months (including the initial period of COBRA coverage)***.

This extension is available to ***the spouse*** and ***eligible children*** if, while they and the covered former employee are purchasing COBRA coverage, the former employee:

- dies,
- enrolls in any part of Medicare
- gets divorced or legally separated.

The extension is also available to an ***eligible child*** when that child stops being eligible under the plan as an eligible child. ***In all of these cases, you must make sure that the Plan Administrator or its designee is notified in writing of the second qualifying event within 60 days after (i) the date of the second qualifying event or (ii) the date coverage is lost, whichever occurs last.*** The plan requires you to follow the procedures specified in the box above, under the heading entitled *"Notice Procedures."* Your notice must also ***name the second qualifying event*** and ***the date it happened***. If the second qualifying event is a divorce or legal separation, your notice must include ***a copy of the divorce decree or legal separation agreement***.

If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee within the required 60-day period, then there will be no extension of COBRA continuation coverage due to the second qualifying event.

3. *Medicare Extension for Spouse and Eligible Children*.
If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to any part of Medicare, then the maximum coverage period for the spouse and eligible children is ***36 months*** from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

Shorter Maximum Coverage Period for Health Flexible Spending Accounts
The maximum COBRA coverage period for a health flexible spending arrangement (health "FSA") maintained by the employer ends on the last day of the cafeteria or flexible benefits plan "plan year" in which the qualifying event occurred. In addition, if at the time of the qualifying event the employee has withdrawn (during the plan year) more from the FSA than the employee has had credited to the FSA, no COBRA right is available at all.

OTHER RULES AND REQUIREMENTS
Same Rights as Active Employees to Add New Dependents. A qualified beneficiary generally has the same rights as similarly situated active employees to add or drop dependents, make enrollment changes during open enrollment, etc. Contact the Plan Administrator for more information. See also the paragraph below titled, *"Children Born or Placed for Adoption with the Covered Employee During COBRA Period,"* for information about how certain children acquired by a covered employee purchasing COBRA coverage may actually be treated as qualified beneficiaries themselves. ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 31 days of the date you wish to make such a change*** *(adding or dropping dependents, for example).* See the rules in the box above, under the heading entitled, *"Notice Procedures,"* for an explanation regarding how your notice should be made.

Children Born to or Placed for Adoption with the Covered Employee During COBRA Period. A child born to, adopted by, or placed for adoption with a covered employee or former employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee or former employee is a qualified beneficiary, the employee has elected COBRA continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the plan, the child must satisfy the otherwise applicable plan eligibility requirements (for example, age requirements). ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 31 days of the date you wish to make such a change.*** See the rules in the box above, under the heading entitled, *"Notice Procedures,"* for an explanation regarding how your notice should be made.

Alternate Recipients Under Qualified Medical Child Support Orders. A child of the covered employee or former employee who is receiving benefits under the plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the employee's period of employment with the employer is entitled the same rights under COBRA as an eligible child of the covered employee, regardless of whether that child would otherwise be considered a dependent. ***Be sure to promptly notify the Plan Administrator or its designee if you need to make a change to your COBRA coverage. The Plan Administrator or its designee must be notified in writing within 31 days of the date you wish to make such a change.*** See the rules in the box above, under the heading entitled, *"Notice Procedures,"* for an explanation regarding how your notice should be made.

Are there other coverage options besides COBRA Continuation Coverage?
Yes, other coverage options not sponsored by your employer may be available. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, 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.

If You Have Questions
Questions concerning your plan or your COBRA continuation rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability or Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at **www.dol.gov/ebsa.**"

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator or its designee informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

Plan Contact Information

David McCauley
Executive Vice President
Global Head of Human Resources Group
Suite 1600 – 200 King Street West
Toronto, Ontario M5H 3T4
Canada
T: 646.794.0553

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Allied World Assurance Company (U.S.) Inc. Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Allied World Assurance Company (U.S.) Inc. Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Standard Plan	**In-Network**	**Out-of-Network**
Individual Deductible	$500	$1,000
Family Deductible	$1,000	$2,000
Coinsurance	20%	40%
HDHP Plan	**In-Network**	**Out-of-Network**
Individual Deductible	$1,500	$3,000
Family Deductible	$3,000	$6,000
Coinsurance	20%	40%

If you would like more information on WHCRA benefits, please refer to your Policy Booklet or contact your Plan Administrator at:

David McCauley
Executive Vice President
646.794.0553

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

Allied World Assurance Company (U.S.) Inc. Wellness Program is a voluntary wellness program available to employees who are covered under the medical plan. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease).

You are not required to complete the HRA or to participate a blood test or other medical examinations.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Allied World Assurance Company (U.S.) Inc. may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a doctor in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact David McCauley at 646.794.0553.

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 January 31, 2022. Contact your State for more information on eligibility –

ALABAMA-Medicaid	CALIFORNIA-Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA-Medicaid	**COLORADO-Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ARKANSAS-Medicaid	**FLORIDA-Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA-Medicaid	MAINE-Medicaid
A 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	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711
INDIANA-Medicaid	**MASSACHUSETTS-Medicaid and CHIP**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840
IOWA-Medicaid and CHIP (Hawki)	**MINNESOTA-Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
KANSAS-Medicaid	**MISSOURI-Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KENTUCKY-Medicaid	**MONTANA-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://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
LOUISIANA-Medicaid	**NEBRASKA-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)	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA-Medicaid	SOUTH CAROLINA-Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
NEW HAMPSHIRE-Medicaid	**SOUTH DAKOTA-Medicaid**
Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW JERSEY-Medicaid and CHIP	**TEXAS-Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NEW YORK-Medicaid	**UTAH-Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH CAROLINA-Medicaid	**VERMONT-Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
NORTH DAKOTA-Medicaid	**VIRGINIA-Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OKLAHOMA-Medicaid and CHIP	**WASHINGTON-Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
OREGON-Medicaid	**WEST VIRGINIA-Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
PENNSYLVANIA-Medicaid	**WISCONSIN-Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
RHODE ISLAND-Medicaid and CHIP	**WYOMING-Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	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 January 31, 2022, 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 1/31/2023)

Questions?

If you have questions relating to the Allied World plans, please contact either:

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Please note that the benefits described in this guide may be changed at any time and does not represent a contractual obligation on the part of Allied World.

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