KRA CORPORATION

Innovative
Exceptional
Trusted

2025

COMPANY BENEFITS GUIDE

The health and welfare of our employees is very important to us. We offer our employees, working a minimum of 30 hours per week, group health and welfare benefits that will help alleviate some of the financial burden in the event of an illness for themselves or their dependents. Keeping our employees healthy and providing insurances that create "peace of mind" is KRA's number one goal.

What's Inside

Important Notice about Your Prescription Drug Coverage and Medicare—see page 16 and 17

Please read this notice and share it with any of your Medicare-eligible dependents.

Eligibility

Employees

Employees working a minimum of 30 hours per week are eligible to participate in the group health and welfare benefits programs described in this guide. Group health and welfare benefits for newly hired employees are effective on the first day of the month following date of hire. Employees must work 40 hours per week for paid leave, holiday pay, and other company-sponsored benefits.

Dependents

In addition to enrolling yourself, you may also enroll any eligible dependents. Eligible dependents are defined below:

- **Spouse**: A person to whom you are legally married by ceremony.
- **Domestic Partner** (a person of the same or opposite sex) who meets the criteria below:
  - Has shared your permanent residence for no less than twelve months
  - Has signed a notarized Domestic Partner Affidavit with you (can be found on the forms page at www.workforcenow.adp.com)
  - Is financially interdependent with you and can provide documentation of at least two of the following: common ownership or lease-hold interest in property; common ownership of a motor vehicle; a joint bank or credit account; designation as a life insurance or retirement plan beneficiary; beneficiary in your partner's will; assignment of durable power of attorney; or any proof deemed to show financial interdependence
  - Is no less than 18 years of age
  - Is not a blood relative that would be prohibited by legal marriage
  - Has not signed a domestic partner affidavit or declaration with another partner in the prior twelve month period
  - Is not currently legally married to another person
  - Does not have any other domestic partner, spouse or equivalent of the same or opposite sex
- **Children**: Your biological, adopted or legal dependent children up to age 26 regardless of student, financial, or marital status.

Making Changes

Please keep in mind that benefit elections and their related payroll deductions cannot be changed until the next annual Open Enrollment period unless you, your spouse/domestic partner, or your dependent child(ren) experience a qualified change-in-status event that impacts your eligibility, and the change is allowed under the terms of the insurance contract or plan document. If you experience a qualified change-in-status event, you must notify your People and Culture Department within **30 days** of the qualifying event in order to request a change to your benefit elections.

Qualified change-in-status events are defined to include the below:

- Legal marital status, including marriage, death of a spouse, divorce, and annulment
- Number of dependents due to birth, death, adoption, and placement for adoption
- Employment for you, your spouse, or your dependent, including commencement of or return from leave of absence, or change in employment status
- Eligibility status of your dependent due to attainment of age, a qualifying event, or any other similar circumstance

How to Enroll

With our online benefits system, selecting your benefits is fast, easy, and convenient.

You can view your benefits information and make decisions and changes online. If you want to make changes to your elections, you may do so any time during the enrollment period, but all changes must be completed by the enrollment deadline.

1. www.workforcenow.adp.com
2. You will use the same username and password used to access your ADP information
3. If you can't remember your username and password, click on forgot user ID and follow the prompts
4. When you log on to ADP, a popup window will be displayed reminding you it is open enrollment time. You will have the option to enroll now or remind later.
5. Follow the onscreen enrollment instructions to enroll yourself and your dependents.

Important Reminders

Check your confirmation statement carefully to be sure all elections have been correctly recorded and that your dependents are properly enrolled for each benefit. Print a copy for your records.

Your enrollment is not complete until you print your enrollment confirmation statement. If you end your online session before printing the statement, your elections will not be recorded.

If you want to make corrections to your elections, you may do so any time during the enrollment period.

Payroll Deductions

24 pay periods per year

Plan	Employee Only	Employee and Child(ren)	Employee and Spouse/Partner	Family
Cigna Medical Level I	$76.57	$164.37	$236.79	$313.90
Cigna Medical Level II	$105.72	$216.84	$303.84	$398.73
Cigna Medical Level III	$165.85	$325.06	$442.13	$573.68
Cigna Dental PPO Base Option	$13.02	$24.08	$30.36	$43.60
Cigna Dental PPO Buy Up Option	$18.73	$34.67	$43.72	$62.77
Cigna Vision	$2.84	$5.74	$5.68	$9.17

Student Loan Assistance

We have partnered with **Peanut Butter** to help our employees tackle student debt. Our student loan assistance program includes:

- Company contributions toward your student loans every month.
- Curated advice and insights to help you restructure your loans and save money.
- Access to a refinancing marketplace designed to get you the best terms possible.
- Free and paid counseling services when you need to phone a friend.

Look for an email invitation from **support@getpeanutbutter.com**.
If you've already received your invitation, you can sign up or login at: **app.getpeanutbutter.com/users/sign_up**

Questions about the program?

Call Peanut Butter at (800) 913-6651 and press 1 for employee support.

Medical Coverage

Keeping you and your family in good health

The health benefits available to you represent a significant component of your compensation package, and they provide important protection to keep you and your family in good health.

Eligible employees have the choice among three medical plans offered through **Cigna**.

Choosing a Primary Care Provider

A Primary Care Provider (PCP) manages all aspects of your health care and is your key resource when you have questions about your health. Selecting a PCP is recommended, although not required.

To locate a participating, in-network provider, visit www.cigna.com and click "Find a Doctor, Dentist, or Facility." Select "Employer or School." Enter your search criteria and choose the OAP medical plan.

Doctor, Urgent Care, and Emergency Care

Your Doctor Knows Best

- Your personal physician best understands your health.
- Having a personal physician can result in overall better care.

But what if you get sick or injured when your doctor's office is closed?

Cigna Members: 24/7 Medical Advice

- The Health Information Line provides advice on a diagnosis or where to receive care.
- Cigna Telehealth Connection gives you access to virtual doctor visits for common, uncomplicated, non-emergency health issues.

Urgent Care Centers

- Urgent care centers are usually open after normal business hours, including evenings and weekends.
- Many urgent care centers offer on-site diagnostic tests.
- In most situations, you'll save time and money by going to urgent care instead of the Emergency Room.

Emergency Room (ER)

- This is the best place for treating severe and life-threatening conditions; ERs are not staffed to focus on minor injuries.
- ERs provide the most expensive type of care.

Preventive Care Covered at 100%

Prevention is the best medicine, and your Cigna medical plans cover a wide range of preventive services to help you and your family lead healthy, productive lives. These services include annual routine examinations, well-child care visits, immunizations, routine OB/GYN visits, mammograms, PAP tests, prostate screenings, and other services as required by the Affordable Care Act. These preventive services are covered in full when you visit a participating, in-network provider.

Cigna Member Resources

myCigna.com

Being better informed can help you make better choices. Cigna's personalized website, **www.mycigna.com**, provides access to your plan information, as well as many online tools with information to help you make more informed health decisions. Want to find out how to improve your fitness or eat better? Cigna's online tools can help you stay active and take care of your health.

Cigna Mobile app

The myCigna mobile app gives you an easy way to organize and access your important health information—anytime, anywhere. Download the free app and gain instant access to multiple services.

24/7 Medical Advice

Cigna Virtual Care

Life is demanding. It's hard to find time to take care of yourself and your family members as it is, never mind when one of you isn't feeling well. That's why your health plan through Cigna includes access to medical and behavioral/mental health virtual care. With Cigna Virtual Care, you can get the care you need—including most prescriptions—for a wide range of minor conditions. You can connect with a board-certified doctor when, where, and how it works best for you—via video or phone—without having to leave home or work. **MDLIVE** televisits can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. Costs are the same or less than a visit with a primary care provider.

Whether it's late at night and your doctor or therapist isn't available, or you just don't have the time or energy to leave the house, you can:

- Access care from anywhere via video or phone
- Get medical virtual care 24/7/365—even on weekends and holidays
- Schedule a behavioral/mental health virtual care appointment online in minutes
- Connect with quality board-certified doctors and pediatricians, as well as licensed counselors and psychiatrists
- Have a prescription sent directly to your local pharmacy, if appropriate

Now, you can even have virtual wellness/preventive screenings at no cost through MDLIVE. Simply make a virtual visit appointment online and then visit a lab for your blood work and biometrics. You will receive a notification when the results are available in the MDLIVE customer portal. Prior to your virtual appointment, your results must be shared with the MDLIVE provider so that your visit will be more focused and informative.

You have options

- **MDLIVE**: medical and behavioral/mental health virtual care: **1-888-726-3171**
- **Cigna Behavioral Health** also provides access to video-based counseling through Cigna's network of providers. To find a provider:
  - Visit **myCigna.com**, go to "Find Care & Costs" and enter "Virtual Counselor" under "Doctor by Type"
  - Call the number on the back of your Cigna ID card 24/7

24-Hour Health Information Line

The 24-Hour Health Information Line (HIL) assists individuals in understanding the right level of treatment at the right time. Trained nurses are available 24 hours a day, seven days a week, 365 days a year to provide health and medical information and direction to the most appropriate resource. To speak with a nurse, call **1-866-494-2111**.

Medical and Prescription Plan Highlights

Eligible employees have the choice among three medical plans offered through **Cigna**. All three plans allow you the flexibility to choose any health care provider when and where treatment is needed. Keep in mind that if you see an out-of-network provider, you will be subject to higher out-of-pocket expenses and balance billing.

Listed below are the costs and copays that you would pay for certain services. Please refer to your plan description for full details.

Plan Features	Low	Medium	High	
	In-Network ONLY You Pay	In-Network ONLY You Pay	In-Network ONLY You Pay	Out-of-Network You Pay
Primary Care Provider (PCP) Required	No	No	No	
Specialist Referrals Required	No	No	No	
Calendar Year Deductible *Amount you must pay before the plan begins to pay benefits for certain services*	$4,000 individual $8,000 family	$2,000 individual $4,000 family	$250 individual $500 family	$1,000 individual $2,000 family
Out-of-Pocket Maximum**				
Medical	$6,250 individual $12,500 family	$5,000 individual $10,000 family	$3,000 individual $6,000 family	$6,000 individual $2,000 family
Prescription Drugs (Individual/family)	Combined with medical out-of-pocket maximum	Combined with medical out-of-pocket maximum	Combined with medical out-of-pocket maximum	
Preventive Care Services				
Well-Child Care (birth to age 16)	No charge*	No charge*	No charge*	20% after deductible
Adult Physical	No charge*	No charge*	No charge*	20% after deductible
Routine GYN visits	No charge*	No charge*	No charge*	20% after deductible
Mammogram	No charge*	No charge*	No charge*	20% after deductible
Cancer Screenings (PAP, prostate, colorectal)	No charge*	No charge*	No charge*	20% after deductible
Office Visits, Labs, and Testing				
Office Visits for Illness (PCP/specialist)	$20/$40 copay	$20/$40 copay	$20 / $40 copay	20% after deductible
Mental Health/Substance Abuse Office Visits	$40 copay	$40 copay	$40 copay	20% after deductible
Lab and X-ray	No charge*	No charge*	No charge*	20% after deductible
Imaging (MRI/CT)	No charge* after deductible	No charge* after deductible	$150 copay after deductible	$300 copay. then 20% after deductible
Urgent Care, Emergency Care, and Hospitalization				
Urgent Care Center	No charge* after deductible	No charge* after deductible	$75 copay	
Hospital Emergency Room	No charge* after deductible	No charge* after deductible	$150 copay	
Inpatient Hospitalization	No charge* after deductible	No charge* after deductible	No charge* after deductible	20% after deductible

** No copays or coinsurance.*

***Out-of-Pocket Maximum: This is the maximum amount you pay toward deductible, coinsurance, copays, and covered expenses per benefit period. Copays, deductibles, and coinsurance accumulate toward the Out-of-Pocket Maximum. Once you have reached the Out-of-Pocket Maximum, the plan will pay 100% for covered services.*

[1]Embedded Deductible—If an individual in the family reaches the individual deductible before the family deductible is met, their services will be paid by the carrier.

[1]Embedded Out-of-Pocket Max—If an individual in the family reaches the individual out-of-pocket max before the family out of pocket max is met, their services will be covered at 100% for the remainder of the plan year.

Plan Features	Low In-Network You Pay	Medium In-Network You Pay	High In-Network You Pay
Prescription Drugs—No deductible			
Retail—up to 30-day supply			
Generic	$10 copay	$10 copay	$10 copay
Preferred brand name	$35 copay	$35 copay	$35 copay
Non-preferred brand name	$60 copay	$60 copay	$60 copay
Mail Order—90-day supply			
Generic	$30 copay	$30 copay	$30 copay
Preferred brand name	$105 copay	$105 copay	$105 copay
Non-preferred brand name	$180 copay	$180 copay	$180 copay

This chart is intended for comparison purposes only. If there are any discrepancies, the plan document will govern. Some services may require preauthorization.

Prescription Drugs

When you enroll in one of the medical plans, you will automatically receive prescription drug coverage. Your prescription drug coverage features the below:

- A 30-day or 90-day supply of drugs available at participating retail locations
- A convenient way to purchase a 90-day supply of your medications and long-term maintenance drugs through mail order
- Educational tools and resources to help you save money, understand your plan, and manage your prescriptions at **www.cigna.com**

Summary of Benefits and Coverage

Choosing a health coverage option is an important decision. To help you make an informed choice, a Summary of Benefits and Coverage (SBC), which summarizes important information in a standard format, is available for review. The SBC is located on the KRA enrollment website at **www.workforcenow.adp.com**. A paper copy is also available, free of charge, by contacting People and Culture.

Please Note: This benefit guide provides a summary of the benefits available. The company reserves the right to modify, amend, suspend or terminate any plan at any time, and for any reason without prior notification. The plans described in this handbook are governed by insurance contracts and plan documents, which are available for examination upon request. Should there be a discrepancy between this handbook and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. Benefits are not a guarantee of employment.

Dental

You have the choice between two dental plan options through **Cigna.** You have the freedom to select the dentist of your choice; however, when you visit a participating, in-network dentist, you will have lower out-of-pocket costs, no balance billing, and claims will be submitted by your dentist on your behalf.

To locate a participating, in-network provider, visit www.mycigna.com.

The features of your dental plan options are highlighted in the table below. Please refer to your plan description for full details.

Plan Features	Dental PPO—Base Option		Dental PPO—Buy Up Option	
	In-Network You Pay	Out-of-Network* You Pay	In-Network You Pay	Out-of-Network* You Pay
Calendar Year Deductible *Amount you must pay before the plan begins to pay benefits for certain services. Waived for preventive and orthodontia*	$50 individual $150 family		$50 individual $150 family	
Annual Benefit Maximum *Maximum amount the plan will pay per calendar year. Waived for preventive and orthodontia.*	Plan pays $1,000 per person per calendar year		Plan pays $1,500 per person per calendar year	
Type A: Preventive and Diagnostic Oral exams, cleanings, x-rays	No charge no deductible	No charge* no deductible	No charge no deductible	No charge* no deductible
Type B: Basic Restorative Fillings, simple extractions, oral surgery, periodontics, endodontics	20% after deductible	20%* after deductible	10% after deductible	10%* after deductible
Type C: Major Restorative Inlays/onlays, bridges, dentures, crowns	50% after deductible	50%* after deductible	40% after deductible	40%* after deductible
Type D: Orthodontia Dependent children only up to age 19 $1,000 lifetime maximum per person	50% up to $1,000	50%	50% up to $1,000	50%

**Plan payments are based on the Maximum Allowable Charge (MAC). Participating dentists accept 100% of the MAC fee as payment in full for covered services. Non-participating dentists (out-of-network) may bill the member for the difference between the MAC fee and their charges.*
This chart is intended for comparison purposes only. If there are any discrepancies, the plan document will govern. Limitations or exclusions may apply.

Prevention First!

Your dental health is an important part of your overall health. Make sure you take advantage of your preventive dental visits. Preventive care services are not subject to the annual deductible and the plan covers 100 percent of the cost in-network!

Vision

Eligible employees have the opportunity to purchase a voluntary vision plan administered through **Cigna**. With this plan you have the ability to use both in-network and out-of-network providers. Please keep in mind that if you choose to seek services from an out-of-network provider, you will be required to pay the provider at the time of service and submit a claim form to Cigna for reimbursement.

To locate a participating, in-network provider, visit www.mycigna.com.

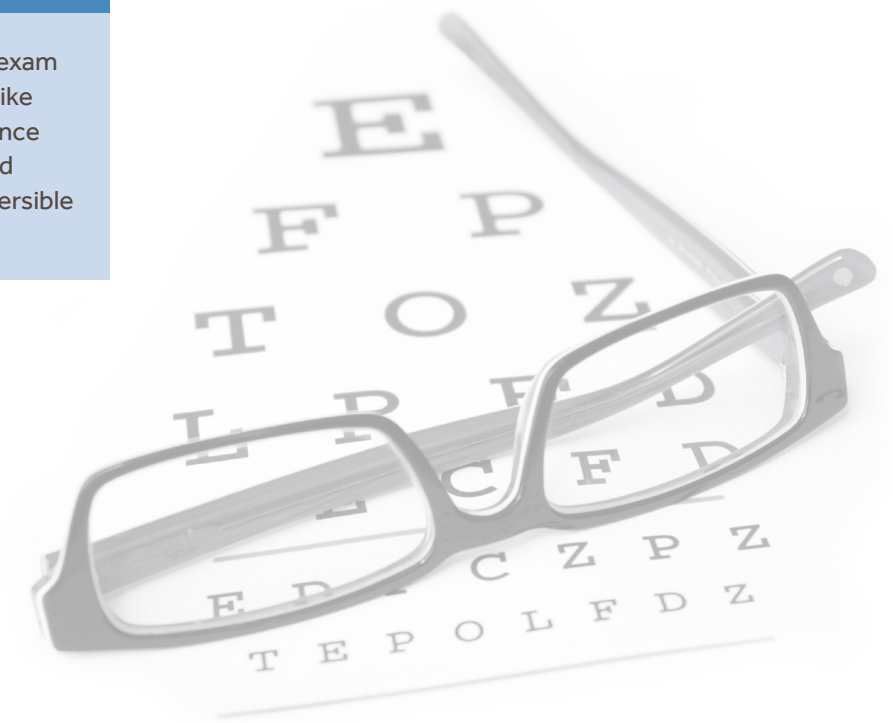
The features of your vision plan are highlighted in the table below. Please refer to your plan description for full details.

Plan Features	In-Network	Out-of-Network Reimbursement
Vision Exam *Once every 12 months*	$10 copay	Up to $45
Eyeglass Frames *Once every 12 months*	$130 plan allowance plus 20% off remaining balance	Up to $71
Eyeglass Lenses *Once every 12 months* Single vision Lined bifocal Lined trifocal	 $25 copay $25 copay $25 copay	 Up to $32 Up to $55 Up to $65
Contact Lenses *Once every 12 months in lieu of eyeglasses* Fitting/Exam Contact Lenses	 Included below $130 allowance	 N/A Up to $105

This chart is intended for comparison purposes only. If there are any discrepancies, the plan document will govern. Limitations or exclusions may apply.

Did you know your eyes can tell an eye care provider a lot about you?

In addition to detecting eye disease, a routine eye exam can help detect signs of serious health conditions like diabetes and high cholesterol. This is important, since you won't always notice the symptoms yourself and since some of these diseases cause early and irreversible damage.



Flexible Spending Accounts

Flexible Spending Accounts (FSAs) help you stretch your budget for eligible health care and dependent care expenses for you and your dependents by allowing you to pay for these expenses using tax-free dollars. There are two types of FSAs: Health Care FSAs and Dependent Care FSAs. The FSAs are administered by **TASC**.

In order to participate in the FSA, **you must enroll each year**. Your annual contribution stays in effect during the entire year (January 1 through December 31). The only time you can change your election is during Open Enrollment or if you experience a qualified change-in-status event.

Health Care FSA

You may set aside up to $3,300 annually in pre-tax dollars, which is deducted out of your pay throughout the year. Funds can be used to pay for qualified health expenses such as deductibles, medical and prescription copays, dental expenses, and vision expenses. You can use the FSA for expenses for yourself, your spouse, and your dependent children. Expenses must be incurred during the plan year and while you are making contributions to the plan. You can be reimbursed up to your full annual election, less any previous reimbursements.

Dependent Care FSA

You may set aside up to $5,000 (or $2,500 of you are married and file taxes separately from your spouse) annually in pre-tax dollars and receive reimbursement to pay for dependent care expenses, which allows you and your spouse to work outside your home, to seek employment, or to attend school full-time. Eligible expenses must be incurred during the plan year and while you are making contributions to the plan. When submitting a claim, you can only be reimbursed up to the amount you have contributed to date, less any previous reimbursements.

Eligible expenses include the below:

- Care for your dependent child who is under the age of 13 whom you can claim as a dependent for tax purposes
- Care for your dependent child who resides with you and who is physically or mentally incapable of caring for him/herself
- Care for your spouse or parent who is physically or mentally incapable of caring for him/herself

Use It or Lose It

When you choose how much to contribute to an FSA, be sure to estimate your expenses carefully. Any money set aside in an FSA must be used for expenses during the plan year or it will be forfeited. You will have 90 days after the end of the year to submit claims incurred during that year.

Commuter/Parking Benefit

Only available to employees with DC-based contracts

With a Transportation Account, employees can establish a pre-tax account through payroll deductions to pay for qualified work-related commuting and/or parking expenses, such as the below:

- Public Transportation
- Commuter Highway Vehicles
- Parking

Eligible commuter expenses must be work-related. Eligible, work-related parking expenses must include parking at or near your place of employment, or at a location from which you commute to work.

Pre-Tax Contribution 2025 Limits–
Commuter: $325/month
– Parking: $325/month

Over-the-Counter (OTC) Medication Reminder

You may use your Health Care FSA to pay for over-the-counter (OTC) medications at a pharmacy, supermarket, or other retail store without a prescription. Insulin, prescription medicines, and some OTC supplies—such as bandages, crutches, blood sugar test kits, contact lens solution, and menstrual products—are also eligible for reimbursement.

Disability Insurance

KRA understands that there may be times of illness or injury that prevent you from working for a period of time. You are provided with both short-term and long-term disability insurance in the event that you become disabled and are unable to work. Disability benefits are administered through **Mutual of Omaha**.

Short-Term Disability (STD)

Short-term disability (STD) coverage replaces a portion of your income when you are unable to work due to an illness or non-work related injury, including maternity. **You will be automatically enrolled; coverage is 100% paid by KRA**.

- Benefit of 60% of weekly earnings up to a maximum benefit of $1,000 per week, for up to 12 weeks. Benefit payments begin after the seventh day of an injury or illness.
- Benefits received under the STD plan are taxable.

Note: If you are a resident of a state that has a state-required disability plan (such as California), you are required to file for benefits under the state plan first and then the supplemental benefits from KRA's disability plans will be integrated with the state payments.

Long-Term Disability (LTD)

Long-term disability (LTD) insurance provides coverage in the event of an extended illness or injury. **You will be automatically enrolled; coverage is 100% paid by KRA**.

- Benefit of 60% of your monthly earnings up to a maximum benefit of $6,000 per month.
- Benefit payments begin after 90 days of continuous disability and continue as long as you remain disabled or until you reach age 65 or Social Security Normal Retirement Age.
- Benefits received under the LTD plan are taxable.
- Pre-existing condition limitations apply.

Employee Wellness Programs

Employee Assistance Program (EAP)

Life's not always easy. Sometimes a personal or professional issue can get in the way of maintaining a healthy, productive life. Your Employee Assistance Program (EAP) can be the answer for you and your family. You have access to unlimited, telephonic consultations with EAP professionals 24/7.

You don't have to handle your problems alone.

Visit **www.mutualofomaha.com/eap** or call 1-800-316-2796 for confidential consultation and resource services.

Lifestyle Wellness Account

For the 2025 plan year, KRA is excited to offer all employees a Lifestyle Wellness Account with funding in the amount of $360 per employee. We recognize that a good work life balance is very important, and we want to help you achieve that. You can use these funds for any approved expense. These items can be things such as massages, home delivery meal kits, mindfulness apps, music apps (Spotify, Audible, etc) gym memberships, workout equipment, and much more!

The funds will be loaded onto a debit card, which can be used to pay for anything they like. If you personally pay for something and then wish to be reimbursed from the Lifestyle Wellness account, you can submit a receipt to **TASC** for reimbursement.

You must designate a beneficiary!

Choosing who will receive your life insurance benefits is an important decision. Please make sure your beneficiary information is up-to-date.

Evidence of Insurability

Mutual of Omaha requires you to show that you are in good health before they will agree to provide certain levels of coverage. This is called "Evidence of Insurability."

You will need to provide Evidence of Insurability when you do any of the below:

- Increase your supplemental life insurance coverage by more than two increments after your initial election
- Waive coverage when you are initially eligible and enroll for the first time at a later date
- Select coverage of any amount over the guaranteed issue amount—five times your annual salary up to $150,000 for employees, $30,000 for spouses

Evidence of Insurability is not required for dependent children.

Life and AD&D Insurance

Life and AD&D insurance is provided through **Mutual of Omaha**. Life insurance helps protect your family from financial risk and sudden loss of income in the event of your death. Accidental Death and Dismemberment (AD&D) insurance provides a separate benefit on top of the life insurance benefit in the event that the insured person sustains an accidental bodily injury and that injury directly causes either a loss of life, limb, or motor function, as defined by the policy, within 365 days after the date of the accident.

Basic Life and AD&D Insurance

Eligible employees receive basic term life and AD&D insurance in the amount of $50,000. If you die as a result of an accident, your beneficiary will receive an additional benefit. For other covered losses, the amount of the benefit is a percentage of the AD&D insurance coverage amount. Benefits begin to reduce at age 65. Evidence of good health is not required. **You will be automatically enrolled; coverage is 100% paid by KRA**.

Supplemental Life and AD&D Insurance

In addition to the basic life and AD&D insurance provided to you by KRA, you may purchase supplemental life and AD&D insurance for yourself, your spouse, or your dependent children. Participation is voluntary, and **premiums are 100% paid by you**.

Important: If you do not elect employee or spousal supplemental life and AD&D insurance when you are first eligible, any amount elected later will be subject to Evidence of Insurability. In order to elect spousal or dependent life insurance, you must first elect employee supplemental life insurance.

Employee Coverage

- Elect coverage in increments of $10,000, up to a maximum benefit of $500,000, not to exceed five times your annual salary.
- The guaranteed issue amount is five times your annual salary up to $150,000.
- Any amount elected above $150,000 will require Evidence of Insurability and will not be in effect until you receive approval from the insurance company.
- Benefits reduce at age 70.

Spousal/Partner Coverage

- Elect coverage in increments of $5,000, up to $250,000, not to exceed the amount you elected for yourself.
- The guaranteed issue for spousal insurance is $30,000. Any amount elected above $30,000 will require Evidence of Insurability and will not be in effect until you receive approval from the insurance company.
- Rates are based on the age of the employee and will terminate at the employee's age of 70

Dependent Children Coverage

- Elect coverage in increments of $1,000 ($2,000 minimum benefit) up to a $10,000 maximum benefit.
- Evidence of Insurability not required

Supplemental Accidental Death and Dismemberment (AD&D) Insurance

Supplemental AD&D insurance is an optional benefit offered to all eligible employees as a financial resource to protect you and your family in the event that your death is a result of an accident.

- The benefits available under supplemental AD&D are equal to the amount you elect for supplemental life.
- **This is a separate benefit election. Supplemental life does not have to be purchased in order to purchase supplemental AD&D.**

Supplemental Life and AD&D Per Pay Rates

Age	Supplemental Life Per Pay Rates per $1,000 of coverage Employee/Spouse/Partner
Under 25	$0.0250
25–29	$0.0300
30–34	$0.0350
35–39	$0.0400
40–44	$0.0500
45–49	$0.0750
50–54	$0.1200
55–59	$0.2250
60–64	$0.3450
65–69	$0.6650
70+	$1.0750
Children	$0.1000 per $1,000 regardless of the number of children covered

Supplemental AD&D Per Pay Rates Employee/Spouse/Partner/Child(ren)
$0.0125 per $1,000 of coverage

Rates based on age of the employee. Spouse coverage terminates at employee's age 70.

Not sure how much life insurance is right for you and your family?

Compare your beneficiaries' assets and expenses to estimate how much insurance you might want to buy. Insurance may be needed to help pay expenses for several years. Consider the factors below:

- **Expenses**
  - Regular expenses such as food, clothing, and other recurring expenses
  - Debts, including car loans, mortgage, or credit cards
  - Education costs for your children
  - Funeral expenses
- **Resources**
  - Savings, spouse's earnings, or other insurance you may have

Additional KRA Benefits

Continuing Education Assistance

Employees must complete six months of employment to be eligible for this benefit. Employees must be working towards a degree or professional certification; that apply to both their job and KRA's business. KRA will reimburse up to 75% of tuition, application, registration, or similar fees upon successful completion up to a maximum $3,000 (per calendar year). Forms are available from People and Culture.

Professional Affiliations

KRA will pay for one professional membership per calendar year, up to a maximum of $300. Employees must complete and submit the appropriate documents to receive approval from Management and People and Culture prior to applying for membership. Forms are available from People and Culture.

Employee Referral Program

KRA's Employee Referral Bonus Program provides cash bonuses to employees who refer qualified employees to the company for full-time positions. Employees will be paid a referral bonus of $1,000. Referral bonuses are paid after the referrer and referred employee have completed 90 days of service. People and Culture personnel are excluded from this program.

Mutual of Omaha's accident insurance gives you something to fall back on.

Accident insurance can help ease the unplanned financial burden by complementing other insurance you may have, including major medical and disability coverage. As medical costs continue to rise, this additional layer of financial protection may make a difference at a time when you and your family need it most.

Accident insurance provides benefits for covered accidental injuries, related services, and treatments. Examples include:

- Dislocations, fractures, and lacerations
- Diagnostic exams, x-rays, and other emergency services
- Ambulance transportation, hospital admission and confinement
- Follow-up/recovery services, including physical therapy and chiropractic care

Accident Insurance Monthly Rates	
Employee	$4.88
Employee + Child(ren)	$7.95
Employee + Spouse	$7.70
Family	$12.60

Critical Illness Monthly Rates $10,000		
	EE/EE + Child	EE + Spouse/ Family
18-29	$4.20	$8.40
30-39	$7.10	$14.20
40-49	$13.90	$27.80
50-59	$25.30	$50.60
60-69	$49.00	$98.00
70-79	$88.90	$177.80
80+	$123.60	$247.20

Accident Insurance

An accident can happen to anyone, and recovery can be costly. Your major medical insurance may pick up most of the tab but leave you with out-of-pocket expenses that add up quickly. With accident insurance, you'll receive a lump-sum payment for a covered injury and related services. You can use the payment in any way you choose—from expenses not covered by your major medical plan to day-to-day costs of living such as the mortgage or your utility bills.

Covered Benefit	Accident Plan Pays (Benefits are Once Per Accident)
Wellness Benefit*	$50
Physician Office Visit	$75once/accident within 72 hours
Physician Office Visit Follow Up	$150 once/accident within 72 hours
Emergency Care Treatment	$1,000 once/accident within 72 hours
Ground Ambulance	$100 once/accident within 365 days
Air Ambulance	$50 once/accident within 90 days
Fracture (Schedule of Benefits)	$100 once/accident within 72 hours
Appliances	Included
Laceration (Schedule of Benefits)	N/A
X-Ray	N/A
Diagnostic Exam	$45,658
Urgent Care Visit	$0

*The plan includes a $50 per year wellness benefit for completing certain routine wellness screenings or procedures. This includes coverage for screenings and procedures such as well visits, mammography, colonoscopy, pap smear, PSA, and Serum cholesterol test.

Critical Illness Insurance

You may elect voluntary critical illness coverage through Mutual of Omaha. This benefit is employee-paid. For critical illness, employees can choose a lump sum benefit of $10,000 for employee and spouse coverage. You may elect a benefit of $3,000 for children. This policy will pay lump sum payments if you have a critical illness. Pre-existing condition limitations apply.

Covered Benefit	Critical Illness Plan Pays
ALS (Lou Gehrig's Disease)	Not covered
Alzheimer's Disease	Not covered
Cancer/Invasive	100%
Coma	Not covered
Cancer/Carcinoma in Situ	25%
Cancer/Skin	25%
Coronary Artery Bypass Surgery	25%
Advanced Parkinson's Disease	Not covered
End Stage Renal Disease/Kidney Failure	100%
Heart Attack	100%
Severe Burns	Not covered
Stroke	100%

Retirement Plan

KRA's Retirement Plan is comprised of two components: a 401(k) Plan and a discretionary Profit-Sharing Plan. Employees 21 years of age, or older, are eligible to participate in the retirement plan on the first of the month following 60 days of employment. Eligible employees will be enrolled automatically for a 3% salary deferral upon their eligibility date. Participants who are enrolled automatically will be subject to an automatic 1% annual deferral increase until the amount withheld reaches 10% of compensation. If you choose not to participate, you must opt-out of the Retirement Plan before your eligibility date.

Employees may set aside up to the annual IRS maximum on a pre-tax basis, through payroll deductions. Participants may select their investment options from several mutual funds. Employees who are automatically enrolled in the Plan and who do not make an investment election will be enrolled in the LifeStyle Fund that most closely matches their expected retirement date. Rollovers are accepted immediately into the plan.

Years of Service	% Vested
Less than 2 years	0%
At least 2 years, but less than 3 years	25%
At least 3 years, but less than 4 years	50%
At least 4 years, but less than 5 years	75%
At least 5 years	100%

Vesting Schedule

Participants are always 100% vested in their salary deferral contribution. The discretionary employer matching contribution is vested based on the illustrated schedule.

Profit Sharing

KRA may contribute an annual discretionary profit sharing allocation to employees' retirement account through this component of the Retirement Plan. KRA may contribute to this account at the end of each calendar year based on the company's fiscal performance.

Company Paid Leave

Full-time, regular employees (as defined by the company) are eligible to receive the following company paid leave benefits: earned paid time off (PTO), sick leave, bereavement leave, jury duty, and paid holiday leave.

- Earned PTO and sick leave will be available for use on the 91st day of employment.
- Once an employee reaches the maximum earned cap, hours will stop accumulating until the employee falls below the maximum earned cap amount.
- Unused sick leave is not paid out at separation of employment.
- 100% of unused PTO is paid out at separation of employment.
- **Note:** please refer to the Employee Handbook for more detail.

		After 3 years	After 5 years	After 10 years	Sick Leave
PTO Earned (Over 12 months)	13 days	15 days	20 days	26 days	5 days
PTO Hours Earned Each Pay Period (Semi-Monthly)	4 hours	5 hours	6.66 hours	8 hours	1.66 days
Maximum Earned Cap	20 days	20 days	25 days	30 days	6 days
Bereavement (Immediate Family Member)	5 days per event				
Jury Duty	Up to 4 days per year				
Holiday	14 Days, including Floating Holidays (Refer to the 2024 holiday schedule for site specific recognized holidays)				

Required Federal Notices

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). WHCRA requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

Breast reconstruction benefits are subject to deductibles and coinsurance limitations that are consistent with those established for medical and surgical benefits under the plan.

Health Insurance Portability and Accountability Act (HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. A copy of the Notice of Privacy Practices is available from the insurance carriers for medical, dental, and vision insurance. A copy of the Notice of Privacy Practices for dental coverage and the Health Care Flexible Spending Account is available from Human Resources.

Newborns' and Mothers' Health Protection Act

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

Special Enrollment Rights

If you are declining enrollment for yourself, or your dependents (including your spouse) because of other health insurance or other group health plan coverage, you may be able to enroll yourself and/or 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' coverage). However, you must request enrollment within 30 days after your previous coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

If you or your dependent lose eligibility for coverage under Medicaid or a State child health plan or if you or your dependent become eligible for State-sponsored premium assistance for the medical plan, you may be able to enroll yourself and/or your dependents in this plan if you request enrollment within 60 days of the date of termination of Medicaid or State child health plan coverage or your eligibility for premium assistance.

Important Notice About Your Prescription Drug Coverage and Medicare

If you and your covered dependents are not currently covered by Medicare and will not become covered by Medicare within the next 12 months, this Notice is for informational purposes only.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with KRA Corporation and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

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

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current coverage with KRA Corporation will not be affected. You can keep this coverage if you join a Medicare drug plan and this plan will coordinate with your Medicare drug coverage. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll

in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.
If you do decide to join a Medicare drug plan and drop your medical and prescription drug coverage through KRA Corporation, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period.

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

You should also know that if you drop or lose your current coverage with KRA Corporation and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed on this notice for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through KRA Corporation changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

Date:	January 1 2025
Sender:	KRA Corporation
Contact:	People & Culture
Phone/Email:	301-562-2300 ext. 1 peopleandculture@kra.com
Address:	5950 Symphony Woods Rd, Suite 211 Columbia, MD 21044

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

New Health Insurance Marketplace Coverage

When key parts of the health care law took effect in 2014, there became a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. In 2018, if the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.56% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact your HR Department.

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

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

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, 2023. Contact your State for more information on eligibility.

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

ALASKA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

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

CALIFORNIA — Medicaid
Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Email: hipp@dhcs.ca.gov

COLORADO — Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://hcpf.colorado.gov/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

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

GEORGIA — Medicaid
A HIPP Website: https://medicaid.georgia.gov/programs/third-party-liability/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid
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

IOWA — Medicaid and CHIP
(Hawki) 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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884

KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/

LOUISIANA – Medicaid
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid
Enrollment Website:
https://www.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: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840

MINNESOTA – Medicaid
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

MISSOURI – Medicaid
Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid
Website: http://www.accessnebraska.ne.gov/
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

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

NEW HAMPSHIRE – Medicaid
Website:
https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345,
ext 5218

NEW JERSEY – Medicaid and CHIP
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

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

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org/
Phone: 1-888-365-3742

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

PENNSYLVANIA – Medicaid
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov/
Phone: 1-888-549-0820

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

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – Medicaid
Website:
http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
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

WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
Website:
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Open Enrollment Information

Open Enrollment will be from November 21, 2024 - December 6, 2024

Important Resources

Benefit	Contact	Phone Number	Website or Email
Any Benefit Questions, Eligibility, Claims Issue Resolution Representatives Available Monday–Friday, 8:00 a.m.–5 p.m. ET	Benefit Resource Center Benefits Hotline	1-855-874-6699	BRCEast@usi.com
Online Enrollment	ADP	1-800-972-7227	**www.workforcenow.adp.com**
Medical and Prescription	Cigna	1-866-494-2111	**www.mycigna.com**
Dental	Cigna	1-800-244-6224	**www.mycigna.com**
Vision	Cigna	1-800-244-6224	**www.mycigna.com**
Life and Disability	Mutual of Omaha	1-800-775-6000	**www.mutualofomaha.com**
Employee Assistance Program (EAP)	Mutual of Omaha	1-800-775-6000	**www.mutualofomaha.com**
Flexible Spending Accounts	TASC	1-800-422-4661	**www.tasconline.com**
Accident Insurance Critical Illness Insurance	Mutual of Omaha	1-800-788-5093	**www.mutualofomaha.com**
Student Loan Assistance	Peanut Butter	1-800-913-6651	**www.getpeanutbutter.com**

KRA is an EEO/AA employer. Employees are employed by KRA "at will." This company benefits guide is only a general overview of certain benefits, and is not intended to create, nor should it or any of its contents be construed to create or constitute, a contract of employment or any other contract between KRA and any of its employees (either express or implied). Although the information in this company benefits guide is believed to be accurate at the time of its last revision, it should not be relied upon. Employees are provided with summary plan descriptions and other documents regarding KRA's benefits and plans; in the event of any discrepancy between this company benefits guide and any such plan document, the plan document shall control. Further, KRA reserves the right to amend, modify, supplement, add, and/or terminate any benefit, in whole or in part, at any time and from time to time. Please contact the People and Culture Department for information and/or questions.

KRA CORPORATION

Innovative
Exceptional
Trusted

5950 Symphony Wood Road, Suite 211
Columbia, MD 21044
www.kra.com