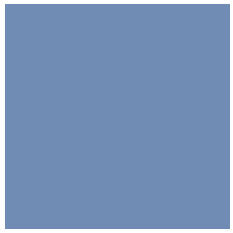
TURNING POINT USA



# 2025-2026 Benefit Guide

**If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 25-28 for more details.**

# Table of Contents

## Contents



This brochure summarizes the benefit plans that are available to Turning Point USA eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.

# A Message to Our Employees

## The Annual Benefits Enrollment Period Is Here!

As healthcare costs continue to rise due to inflation and increased government regulation, the cost to provide healthcare coverage has also increased. Additionally, Turning Point USA has seen an increase in the occurrence and severity of claims of healthcare costs. This has been a common scenario across the market as costs increase to keep pace with healthcare trends. Turning Point USA is committed to providing a comprehensive benefits package to its employees for the following year. We have made the following changes to the 2025-2026 offerings as highlighted below.

## 2025-2026 Benefit Plans Highlights

- **GREAT NEWS! No change in Contributions for 11/1/25!**
- **MEDICAL**
  - $3,200 Plan: IRS required deductible change to HSA-qualified plan: Increase to $3,300 (individual)/$6,600 (family).
  - New Blue Cross Blue Shield of Arizona Medical ID Cards with ***updated alpha prefix*** – everyone will receive a new ID card. It is important to make sure you are using the new ID card with prefix **P9H (3 digits before your Identification number)** on or after 11/1/25.
- **DENTAL –** Coverage will remain with Guardian.
- **VISION** – Coverage will remain with Guardian.
- **SHORT-TERM DISABILITY** – Coverage will remain with Guardian.
- **VOLUNTARY LIFE & AD&D** – Coverage will remain with Guardian.
- **ACCIDENT** – Coverage will remain with Guardian.
- **CRITICAL ILLNESS** – Coverage will remain with Guardian.

# Benefits Eligibility

Turning Point USA is pleased to announce our 2025-2026 benefits program, designed to help you stay healthy, feel secure, and maintain a work/life balance. We strive to provide our employees with a rewarding workplace by offering a competitive benefits package. Please read the information provided in this guide carefully. Please refer to the summary plan descriptions for full details about our plans. Listed below are the Turning Point USA benefits available during open enrollment:

- Medical
- Dental
- Vision
- Voluntary Life and AD&D
- Short-Term Disability
- Accident
- Critical Illness

## Who is Eligible?

Full-time employees working at least 30 hours per week may participate in the Turning Point USA benefits program. Once you are eligible for the plans, your eligible dependents are as well.

Generally, for the Turning Point USA benefits program, dependents are defined as:

- Your legally married spouse; or your domestic partner.
- Your dependent child up to age 26. (Child means the employee's natural child or adopted child and child(ren) of your domestic partner, and any other child as defined in the certificate of coverage).

## Changing Coverage During the Year

You can change your coverage during the year when you experience a qualified change in status, such as marriage, divorce, birth, adoption, placement for adoption, or loss of coverage. The change must be reported to the Human Resources Department within 30 days of the event and must be consistent with it.

For example, if your dependent child no longer meets eligibility requirements, you can drop coverage only for that dependent.

**Your online enrollment is available through Payroll Experts. If you have any issues completing your enrollment, please contact Human Resources.**

# Medical Plan Information

Turning Point USA will continue to partner with Blue Cross Blue Shield of Arizona (BCBS) for your medical benefits. You have a choice of five medical plan options to choose from. All plans utilize the same national network of doctors and hospitals called Statewide. To search for a doctor, visit www.azblue.com. Once you become a member, you should register for your portal to access your claims, pharmacy benefits, explanation of benefits, discount programs, view your digital ID card, and more.

## Traditional PPO/Copay Plans

Two of the five medical plans are traditional PPO Plans with Copays.

- PPO $5,000 Plan – This plan provides catastrophic coverage with a lower payroll deduction.
- PPO $3,000 Plan – This plan provides enhanced coverage with a higher payroll deduction.

## HDHP Plans

Three of the five medical plans are HSA-qualified High Deductible Health Plans (HDHPs).

- HSA $6,000 Plan – This plan provides catastrophic coverage with the lowest payroll deduction.
- HSA $4,000 Plan – This plan provides enhanced coverage with the medium payroll deduction.
- HSA $3,300 Plan – This plan provides the highest level of benefits with the highest payroll deduction.

## Understand Insurance Terms

Learn more about each type of plan by selecting an image or scanning a QR Code.






# Medical Insurance – Traditional PPO Plans

The following chart is a brief outline of the available plans. Please refer to the summary plan description for complete plan details. Note – the deductible and out-of-pocket maximums accumulate on a calendar year basis.

| | BCBS of Arizona PPO $5,000 70% Statewide | | BCBS of Arizona PPO $3,000 70% Statewide | |
|---|---|---|---|---|
| **Benefit Coverage** | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Calendar Year Deductible** | | | | |
| Individual | $5,000 | $10,000 | $3,000 | $6,000 |
| Family | $10,000 | $20,000 | $6,000 | $12,000 |
| Coinsurance | 70% paid by BCBS | 50% paid by BCBS | 70% paid by BCBS | 50% paid by BCBS |
| **Calendar Year Maximum Out-of-Pocket** | | | | |
| Individual | $6,600 | $13,200 | $6,350 | $12,700 |
| Family | $13,200 | $26,400 | $12,700 | $25,400 |
| **Physician Office Visit** | | | | |
| Primary Care | $25 copay | 50% after deductible | $25 copay | 50% after deductible |
| Specialty Care | $75 copay | 50% after deductible | $60 copay | 50% after deductible |
| **Preventive Care** | | | | |
| Adult Periodic Exams | 100% covered | 50% after deductible | 100% covered | 50% after deductible |
| Well-Child Care | 100% covered | 50% after deductible | 100% covered | 50% after deductible |
| **Diagnostic Services** | | | | |
| X-ray and Lab Tests | 70% after deductible | 50% after deductible | 70% after deductible | 50% after deductible |
| Complex Radiology | 70% after deductible | 50% after deductible | 70% after deductible | 50% after deductible |
| Urgent Care Facility | $75 copay | 50% after deductible | $60 copay | 50% after deductible |
| Emergency Room Facility Charges | $450 copay | $450 copay | $400 copay | $400 copay |
| Inpatient Facility Charges | 70% after deductible | 50% after deductible | 70% after deductible | 50% after deductible |
| Outpatient Facility and Surgical Charges | 70% after deductible | 50% after deductible | 70% after deductible | 50% after deductible |
| **Retail Pharmacy (30 Day Supply)** | | | | |
| Tier 1 | $15 copay | $15 copay | $15 copay | $15 copay |
| Tier 2 | $55 copay | $55 copay | $55 copay | $55 copay |
| Tier 3 | $85 copay | $85 copay | $85 copay | $85 copay |
| Tier 4 | $150 copay | $150 copay | $150 copay | $150 copay |
| Specialty Drugs | $60 / $110 / $160 / $210 | Not covered | $60 / $110 / $160 / $210 | Not covered |
| **Mail Order Pharmacy (90 Day Supply)** | | | | |
| Tier 1 | $30 copay | Not covered | $30 copay | Not covered |
| Tier 2 | $110 copay | Not covered | $110 copay | Not covered |
| Tier 3 | $170 copay | Not covered | $170 copay | Not covered |
| Tier 4 | $300 copay | Not covered | $300 copay | Not covered |

| **Employee Contributions (Bi-Weekly Paycheck)** | | |
|---|---|---|
| | PPO $5,000 70% Statewide | PPO $3,000 70% Statewide |
| Employee | $60.77 | $66.52 |
| Employee & Spouse | $289.67 | $317.10 |
| Employee & Child(ren) | $230.93 | $252.79 |
| Family | $453.76 | $496.72 |

# Medical Insurance – HDHP Plans

The following chart is a brief outline of the available plans. Please refer to the summary plan description for complete plan details. Note – the deductible and out-of-pocket maximums accumulate on a calendar year basis.

| | BCBS of Arizona HSA $6,000 70% Statewide | |
|---|---|---|
| **Benefit Coverage** | In-Network | Out-of-Network |
| **Calendar Year Deductible** | | |
| Individual | $6,000 | $12,000 |
| Family | $12,000 | $24,000 |
| Coinsurance | 70% paid by BCBS | 50% paid by BCBS |
| **Calendar Year Maximum Out-of-Pocket** | | |
| Individual | $8,050 | $16,100 |
| Family | $16,100 | $32,020 |
| **Physician Office Visit** | | |
| Primary Care | 70% after deductible | 50% after deductible |
| Specialty Care | 70% after deductible | 50% after deductible |
| **Preventive Care** | | |
| Adult Periodic Exams | 100% covered | 50% after deductible |
| Well-Child Care | 100% covered | 50% after deductible |
| **Diagnostic Services** | | |
| X-ray and Lab Tests | 70% after deductible | 50% after deductible |
| Complex Radiology | 70% after deductible | 50% after deductible |
| Urgent Care Facility | 70% after deductible | 50% after deductible |
| Emergency Room Facility Charges | 70% after deductible | 50% after deductible |
| Inpatient Facility Charges | 70% after deductible | 50% after deductible |
| Outpatient Facility and Surgical Charges | 70% after deductible | 50% after deductible |
| **Retail Pharmacy (30 day Supply)** | | |
| Tier 1 | 70% after deductible | 50% after deductible |
| Tier 2 | 70% after deductible | 50% after deductible |
| Tier 3 | 70% after deductible | 50% after deductible |
| Tier 4 | 70% after deductible | 50% after deductible |
| Specialty Drugs | 70% after deductible | Not covered |
| **Mail Order Pharmacy (90 day Supply)** | | |
| Tier 1 | 70% after deductible | Not covered |
| Tier 2 | 70% after deductible | Not covered |
| Tier 3 | 70% after deductible | Not covered |
| Tier 4 | 70% after deductible | Not covered |
| **Employee Contributions (Bi-Weekly Paycheck)** | | |
| | **HSA $6,000 70% Statewide** | |
| Employee | $55.52 | |
| Employee & Spouse | $264.62 | |
| Employee & Child(ren) | $210.96 | |
| Family | $414.51 | |

# Medical Insurance – HDHP Plans

The following chart is a brief outline of the available plans. Please refer to the summary plan description for complete plan details. Note – the deductible and out-of-pocket maximums accumulate on a calendar year basis.

| | BCBS of Arizona HSA $4,000 100% Statewide | | BCBS of Arizona HSA $3,300 100% Statewide | |
|---|---|---|---|---|
| **Benefit Coverage** | In-Network | Out-of-Network | In-Network | Out-of-Network |
| **Calendar Year Deductible** | | | | |
| Individual | $4,000 | $8,000 | ***$3,300*** | ***$6,600*** |
| Family | $8,000 | $16,000 | ***$6,600*** | ***$13,200*** |
| Coinsurance | 100% paid by BCBS | 100% paid by BCBS | 100% paid by BCBS | 100% paid by BCBS |
| **Calendar Year Maximum Out-of-Pocket** | | | | |
| Individual | $4,000 | $8,000 | ***$3,300*** | ***$6,600*** |
| Family | $8,000 | $16,000 | ***$6,600*** | ***$13,200*** |
| **Physician Office Visit** | | | | |
| Primary Care | 100% after deductible | 100% after deductible | 100% after deductible | 100% after deductible |
| Specialty Care | 100% after deductible | 100% after deductible | 100% after deductible | 100% after deductible |
| **Preventive Care** | | | | |
| Adult Periodic Exams | 100% covered | 100% after deductible | 100% covered | 100% after deductible |
| Well-Child Care | 100% covered | 100% after deductible | 100% covered | 100% after deductible |
| **Diagnostic Services** | | | | |
| X-ray and Lab Tests | 100% after deductible | 100% after deductible | 100% after deductible | 100% after deductible |
| Complex Radiology | 100% after deductible | 100% after deductible | 100% after deductible | 100% after deductible |
| Urgent Care Facility | 100% after deductible | 100% after deductible | 100% after deductible | 100% after deductible |
| Emergency Room Facility Charges | 100% after deductible | 100% after deductible | 100% after deductible | 100% after deductible |
| Inpatient Facility Charges | 100% after deductible | 100% after deductible | 100% after deductible | 100% after deductible |
| Outpatient Facility and Surgical Charges | 100% after deductible | 100% after deductible | 100% after deductible | 100% after deductible |
| **Retail Pharmacy (30 Day Supply)** | | | | |
| Tier 1 | 100% after deductible | 100% after deductible | 100% after deductible | 100% after deductible |
| Tier 2 | 100% after deductible | 100% after deductible | 100% after deductible | 100% after deductible |
| Tier 3 | 100% after deductible | 100% after deductible | 100% after deductible | 100% after deductible |
| Tier 4 | 100% after deductible | 100% after deductible | 100% after deductible | 100% after deductible |
| Specialty Drugs | 100% after deductible | Not covered | 100% after deductible | Not covered |
| **Mail Order Pharmacy (90 Day Supply)** | | | | |
| Tier 1 | 100% after deductible | Not covered | 100% after deductible | Not covered |
| Tier 2 | 100% after deductible | Not covered | 100% after deductible | Not covered |
| Tier 3 | 100% after deductible | Not covered | 100% after deductible | Not covered |
| Tier 4 | 100% after deductible | Not covered | 100% after deductible | Not covered |

**Employee Contributions (Bi-Weekly Paycheck)**

| | HSA $4,000 100% Statewide | HSA $3,000 100% Statewide |
|---|---|---|
| Employee | $66.99 | $71.91 |
| Employee & Spouse | $319.35 | $342.81 |
| Employee & Child(ren) | $254.59 | $273.29 |
| Family | $500.25 | $536.99 |

# Health Savings Account (HSA) – HealthEquity

## Do you Qualify for a Health Savings Account (HSA)?

Though everyone can enroll in the BCBS High Deductible Health Plans (HDHP), not everyone is eligible to open and contribute to an HSA. If you do not meet these requirements, you cannot open an HSA.

- You must be enrolled in one of the three BCBS HSA Plans – $6,000, $4,000, or $3,300
- You must not be covered by another non-HDHP health plan, such as a spouse's PPO plan.
- You are not enrolled in Medicare.
- You are not in the TRICARE or TRICARE for Life military benefits program.
- You have not received Veterans Administration (VA) benefits within the past three months.
- You are not claimed as a dependent on another person's tax return.
- You are not covered by a traditional health care flexible spending account (FSA). This includes your spouse's FSA. (Enrollment in a limited-purpose health care FSA is allowed).

## What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is a tax-advantaged savings account owned by an individual that can be used to pay for qualified medical expenses for the owner and their dependents. An HSA, which must be paired with an HSA-qualified health plan, allows you to make pre-tax contributions that can be used to pay for qualified medical expenses, including medical, dental, vision, and pharmacy expenses. Use your HSA debit card to pay for a qualifying expense. Or, if you don't have a debit card, pay for the expense and submit it to your HSA for reimbursement.

## HSA Triple Tax Benefits

1. **Reduces federal income taxes**: When you contribute to an HSA directly from your paycheck, you reduce your federal income tax by the amount you deposit in your HSA.
2. **Tax-free interest**: Money in an HSA earns interest, and you do not pay taxes on the interest earned. Any gains on dollars invested in mutual funds are also tax-free.
3. **Tax-free withdrawals**: You never pay taxes on HSA withdrawals when used to pay for qualified medical expenses.

## Advantages of an HSA

- There is no "use it or lose it" rule; your balance carries over from year to year.
- The HSA is yours to keep, even if you change jobs or medical plans.
- At age 65, HSA funds can be withdrawn for any reason and are taxed as income, just like an IRA or 401(K).

### HSA Contribution Limits

You can contribute to your Health Savings Account on a pre-tax basis through payroll deductions up to the IRS statutory maximums. The IRS establishes the HSA maximums each calendar year.

The 2025 Limits – $4,300 Individual / $8,550 Family

The 2026 Limits – $4,400 Individual / $8,750 Family

If you are age 55 and over, you may contribute an extra $1,000 catch up contribution.

# Health Savings Account (HSA) – HealthEquity

## Frequently Asked Questions (FAQs)

**Q: Who can use the money in my HSA?**
A: You may use the money in the HSA to pay for qualified expenses for you, your spouse, and dependents. You can use the money for expenses for your spouse and dependents, even if they are not enrolled in the HDHP.

**Q: Do I need documentation to prove my expenses were qualified?**
A: Generally, you will not need to provide documentation when withdrawing funds but keep your receipts! If you are audited, you will need to prove to the IRS that distributions from the HSA were used for qualified health care expenses

**Q: What are Qualified Expenses?**
A: To see more qualified expenses, visit https://www.healthequity.com/hsa-qme. See IRS Publication 969 for more information.

**Q: What happens if I use the money in my HSA for non-qualified expenses?**
A: If you're under 65, you must pay a 20% penalty and taxes on the withdrawn funds. If you're 65 or older, you will only have to pay taxes on the funds but will not have to pay the penalty.

**Q: What if I change from HSA to PPO?**
A: You can no longer contribute to the HSA, but you can still spend the funds on eligible expenses, such as copays on PPO plans.

**Q: How do I enroll in the HSA bank account?**
A: When you enroll online into a qualifying BCBS medical plan, there will be an HSA section that requires you to elect an annual amount to elect towards your HSA.

**Q: After enrolling, can I change the HSA amount I elected?**
A: Yes, you will need to notify Human Resources.

**Q: What are other eligible expenses?**
A: You can use it for COBRA premiums, and Medicare premiums, and while receiving unemployment compensation your premiums for coverage are eligible expenses.

| While we cannot recommend a plan for you, some things to consider when selecting your medical plan. | | |
|---|---|---|
| | **HDHP Plan** | **Traditional PPO/Copay Plan** |
| **What type of user are you of medical insurance – low, medium, or high?** | Low and high users of medical insurance can benefit from this arrangement. The medium user may want to consider a PPO plan. | This plan is good for low, medium, and high utilizers of the plan. |
| **Do you take expensive or several prescription drugs?** | If yes, are you comfortable paying 100% of the cost up to your deductible and the out-of-pocket maximum? | If yes, the deductible does not apply and there are set copays per prescription type. |
| **Are you looking for a tax-advantaged savings method?** | If yes, this plan allows you to set aside money in an HSA that you can use for healthcare expenses or retirement. | If yes, this plan does not provide access to any special accounts like an HSA. |
| **Which plan is better?** | Both are quality plans.<br>It just depends on your financial situation, medical needs, and long-term financial goals and objectives. Both plans provide comprehensive coverage and include an out-of-pocket maximum (though the amount varies based on plan selection). | |

BlueCross BlueShield Arizona

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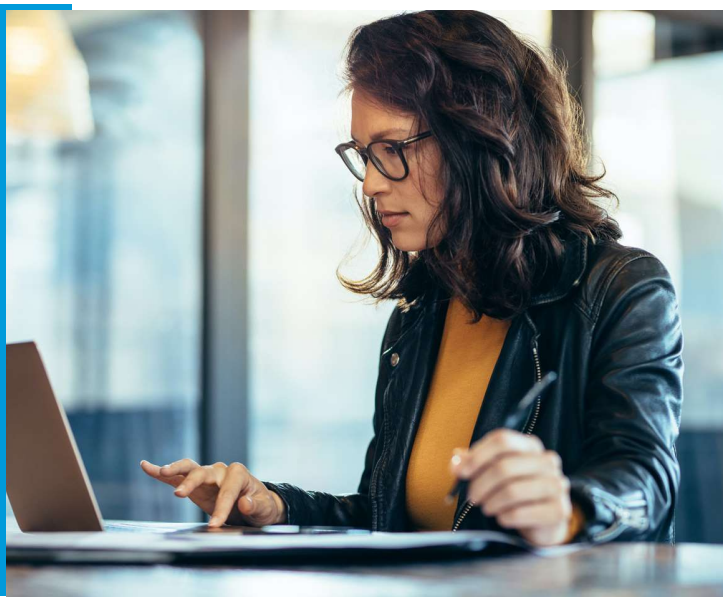
# Need Your Benefits Before Your ID Card Arrives?



## We've Got You Covered

Your employer has recently contracted with Blue Cross® Blue Shield® of Arizona (BCBSAZ) to provide or administer healthcare coverage. BCBSAZ wants to make sure you can access your available benefits as soon as your coverage is effective, even if you haven't yet received your ID card and welcome letter. This flyer explains how to access your benefits and obtain covered services if you don't yet have your BCBSAZ ID card and coverage materials.

## Need to fill prescriptions?*

First, confirm that your pharmacy is contracted with BCBSAZ. You can find a participating pharmacy by going to **azblue.com/findadoctor,** selecting your network, and searching for "Pharmacy" under **Places By Type.** Let the pharmacy know you are a member of a newly enrolled group with BCBSAZ insurance, but you haven't yet received your ID card. Please provide as much information as possible to the pharmacy, such as the:

- Employer's group policy number (available from your employer)
- Name of the employer's business
- Covered employee's full name
- Covered employee's date of birth
- Effective date of your group health insurance coverage (available from your employer)
- BCBSAZ BIN number 603017 (some participating pharmacies can submit the claim online using the BIN number)

If your pharmacy would like assistance in submitting a claim online, they can reach the BCBSAZ Prescription Benefits Unit at **1-866-325-1794** (available 24/7).

Some pharmacies may still require you to pay the retail cost for prescriptions until you have your ID card. If you pay for prescriptions before you receive your ID card, please follow the steps outlined below:

- Be sure you get itemized prescription receipts at the pharmacy.
- Mail the original prescription receipts (or photocopies) and the Prescription Reimbursement Form to:

  BCBSAZ
  Mail Stop A115
  P.O. Box 13466
  Phoenix, AZ 85002-3466

  Receipts should include the name of the member (patient), medication name, the prescribing doctor's name, quantity, NDC number, pharmacy name, and amount paid. You can find the Prescription Reimbursement Form at **azblue.com/individualsandfamilies/resources/forms** when you click on **Pharmacy Claims.**

BlueCross BlueShield Arizona

*HMO plan members: Except for emergency situations, in-network pharmacies must be used for prescriptions to be covered.

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## If your provider needs to verify benefits or precertify treatment:

They should call the Provider Assistance number below and explain that you are a member of a newly enrolled group who does not yet have your ID card. Your provider will need to give the following information to the representative:

- Group policy number (available from your employer)
- Name of your employer
- Covered employee's full name
- Covered employee's date of birth
- Effective date of your group health insurance coverage (available from your employer)

## Call us for assistance

Prescription Benefits Unit *(available 24/7)*

**1-866-325-1794**

Provider Assistance

(These numbers are for use by physicians, hospitals, and ancillary providers only. Covered members should call the customer service number listed above.)

**602-864-4320 or**

**1-800-232-2345 ext. 4320**

Once you receive your BCBSAZ ID card, use it to receive covered services and in all correspondence with medical providers or the BCBSAZ Customer Service and Claims departments.

This is not a guarantee of coverage. Only BCBSAZ has the authority to approve coverage and assign rates and effective dates of coverage.



BlueCross BlueShield Arizona

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BlueCross BlueShield Arizona

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# 5 Easy Ways to **Access Your Benefits**

### AZ Blue ID Card

Use the ID card you get in the mail. Renewing? Last year's card also works.

### Printed ID Card

Log in to your account and print your ID card (front & back) at home.

### Digital ID Card

Log in to your account and email a PDF or text a screen shot of your card (front & back) to your provider.

### Digital Credentials

Add key eligibility information to your "mobile wallet."

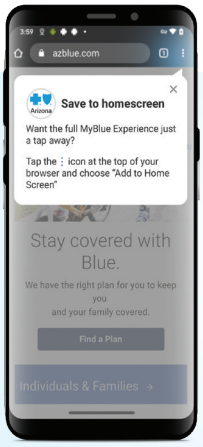

### Member Search

Provide your last name, member ID, and date of birth to your provider to verify coverage.

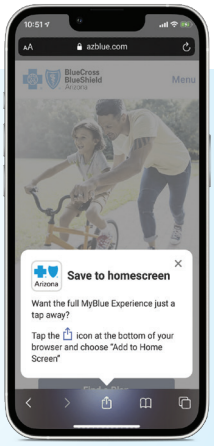
## Stay connected with AZ Blue at home or on the go.

Access benefits quickly with your AZ Blue Portal account at azblue.com/member.

**Add to your homescreen**




Tap the three dots icon on the top right of your **Chrome** browser and choose "Add to Home Screen."




Click share icon on your **Safari** browser, scroll down, and select "Add to Home Screen."

## Help is always a click or call away!

24-7 help at azblue.com

Call us at 1-800-232-2345

Email us at memberhelp@azblue.com

1809808-24

BlueCare Anywhere℠


# Make your mental health a priority.

## It's easy using BlueCare Anywhere℠.

BlueCare Anywhere makes it easy to see a licensed therapist or board-certified psychiatrist on your phone, tablet, or computer. Schedule a visit when it's convenient for you—appointments are available seven days a week, day or night. The best part is online therapy visits are a covered benefit under your Blue Cross® Blue Shield® of Arizona health plan and typically cost the same or less than an in-person office visit.

### Our therapist can provide support when you're coping with:

- Stress
- Life transitions
- Anxiety
- Relationship troubles
- Depression
- Grief
- Illness
- Panic attacks
- And more

### Sign up for free today and talk to a therapist in fewer than four days.*

BlueCare Anywhere℠

DOWNLOAD THE **BlueCare Anywhere** APP
OR VISIT **BlueCareAnywhereAZ.com** NOW.

BlueCross BlueShield Arizona

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*Appointments are subject to availability. Online counseling isn't appropriate for all kinds of problems. If you're in crisis or having suicidal thoughts, it's important that you seek help immediately. Please call 1-800-784-2433 (National Suicide Prevention Lifeline) or 911 for help. If your issue is an emergency, call 911 or go to your nearest emergency room. BlueCare Anywhere doesn't offer emergency services.

Prices may vary by service and BCBSAZ health plan. Check your Summary of Benefits and Coverage for more information. Blue Cross, Blue Shield, and the Cross and Shield Symbols are registered service marks of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. BlueCare Anywhere is a service mark of Blue Cross Blue Shield of Arizona, Inc. Other logos are the property of their respective owners.



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BlueCross BlueShield Arizona

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Unwinding by sharecare

# Stress less

## Feel better with Unwinding by Sharecare.

Unwinding is the app you've been looking for to help you reduce stress and feel less anxious throughout the day.


## Key features:

**Mini courses:** Short video and audio courses on how your mind works and how to use mindfulness to reduce stress and anxiety

**Exercises:** Guided breathing exercises to help you de-stress quickly

**Tools:** Evidence-based mindfulness tools, including guided meditations, that build resilience and decrease chronic stress

**Sleep support:** Including meditations and white noise tracks to help you get to sleep and stay asleep

**Visual relaxation:** Award-winning videos to help you relax

### How do I sign up?

Eligible members can access Unwinding by signing in to their Sharecare account or registering at **azblue.sharecare.com**. Navigate to '**Achieve**', select '**Programs**' and then select '**Unwinding**'.

**Note:** First time users must login via SSO with your Sharecare credentials.



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# Dental Insurance

Turning Point USA will continue to partner with Guardian. You have a choice of two dental plans to choose from. Both plans utilize the same national network of dentists called DentalGuard Preferred. To search for a contracted dentist, visit www.guardianlife.com. Once you become a member, it's recommended that you get registered for your personal portal so you can access secure information about your benefits including your ID card.

The cost for both plans is the same so you will want to make your decision based on the services you will use. The biggest difference between them is:

- Option 1 – The **NAP Plan** is good for members who do not use a contracted dentist because the out-of-network reimbursement.
- Option 2 – The **Value Plan** is good for members who are using a contracted dentist. This plan also has higher coinsurance levels for basic and major services.

The chart below is a brief outline of the plan. Please refer to the summary plan description for complete plan details.

| Benefit Coverage | Dual Option Dental PPO | |
|---|---|---|
| | Option 1 – NAP | Option 2 – Value |
| **Calendar Year Deductible** | | |
| Individual - In / Out of network | $50 / $50 | $50 / $50 |
| Family | 3 per family | 3 per family |
| Waived for Preventive Care? | Yes | Yes |
| | | |
| Annual Benefit Maximum | $1,000 per covered person | $1,000 per covered person |
| Preventive Services | 100% | 100% |
| Basic Services | 80% | 100% |
| Major Services | 50% | 60% |
| Annual Benefit Maximum Rollover | $500 Threshold / $250 Rollover Max / $1,000 Account Max | |
| Benefit Waiting Period | None | |

| Employee Contributions (Bi-Weekly Paycheck) | |
|---|---|
| | NAP & Value Dental PPO Plans |
| Employee | $0.00 |
| Employee & Spouse | $11.88 |
| Employee & Child(ren) | $17.10 |
| Employee & Family | $31.61 |

**Maximum Rollover Rewards Program**

Regular visits to the dentist can help prevent and detect the early signs of serious diseases. That's why Guardian's Maximum Rollover Rewards Program encourages and rewards those who visit the dentist by rolling up to $250 per year of your unused annual maximum into an account that can be used in future years. In addition, Guardian will provide $350 if you only use in-network providers during the plan year. To find out if you have rollover rewards contact Guardian by phone or visit www.guardianlife.com.

# Vision Insurance

Turning Point USA will continue to offer a vision program through Guardian. The network of providers is called VSP Choice Network.

To locate a contracted optometrist, visit www.guardianlife.com and click on Find a Provider. Once you become a member, it's recommended that you get registered for your personal portal so you can access secure information about your benefits including your ID card.

| | Vision PPO Plan |
|---|---|
| **Exam – every 12 months** | |
| Routine Exams | $10 copay |
| **Standard Lenses – every 12 months** | |
| - Single Vision<br>- Lined Bifocal<br>- Lined Trifocal<br>- Lenticular | $25 copay<br>$25 copay<br>$25 copay<br>$25 copay |
| **Contacts – every 12 months** | |
| Contacts (in lieu of frames) | $130 allowance, 15% off balance |
| **Frames – every 24 months** | |
| Frames | $130 allowance, 20% off balance |

| Employee Contributions (Bi-Weekly Paycheck) | |
|---|---|
| **Vision** | |
| Employee | $0.00 |
| Employee & Spouse | $1.98 |
| Employee & Child(ren) | $2.07 |
| Employee & Family | $4.98 |

**Laser Correction Surgery**

Discounts on average of 10-20% off usual and customary charge or 5% off promotional price for vision laser surgery. Members out-of-pocket costs are limited to $1,800 per eye for LASIK or $1,500 per eye for PRK, or $2,300 per eye for Custom LASIK, Custom PRK, or Bladeless LASIK. You are required to stay in-network to take advantage of the discounts.

# Short-Term Disability Insurance

Turning Point USA provides short-term disability for all eligible employees through Guardian Life Insurance Company. Your employer pays 100% of the premium and you're automatically enrolled.

Disability coverage is important because it's a form of paycheck insurance, protecting 60% of your pay if you're unable to work due to an illness or injury. The benefit covers 60% of your pay up to $2,500 per week. The benefit begins after 14 days of injury or illness and lasts up to 11 weeks. For maternity claims, the 14 days will be waived. Please see the summary plan description for complete plan details.

# Guardian Anytime & Value-Added Programs

If you enroll in Guardian benefits, it's recommended that you get registered for your personal account by visiting www.guardiananytime.com. Members and dependents can access helpful benefits information such as:

- Check the status of a claim or evidence of insurability
- Review benefits and locate a provider anytime
- View or print ID cards

## Employee Assistance Program (EAP)

Employees must be eligible for benefits and covered by the Short-Term Disability to access the EAP. Guardian partners with Guidance Resources provide confidential counseling, expert guidance, and valuable resources to help you handle any of life's challenges, big or small. How to access, call 855-239-0743 or visit www.guidanceresources.com and be sure to utilize the Web ID **Guardian**.

## Living Wills

Employees who enroll in the Voluntary Life/AD&D product have access to this benefit. Guardian partners with EstateGuide to provide access to create a customized will at no cost through a simple and secure online tool. Draft a living will for end-of-life care for $14.99. Draft a final arrangements document to express preferences for funeral services for $9.99. For more information, call 855-239-0743 or visit www.estateguidance.com and enter promotional code **Guardian**.

## Global Emergency Assistance Services

Employees who enroll in the accident product have access to this benefit. Guardian partners with Assist America to provide medical emergency assistance while traveling more than 100 miles away from home or outside the country for up to 90 days. When accessing this benefit, be sure to utilize **Reference Number 01-AA-GLI-10231**. For more information, call 800-872-1414 inside the US or 609-986-1234 outside the US, or email them at medservices@assistamerica.com.

# Voluntary Life and AD&D Insurance

Turning Point USA offers Voluntary Life and Accidental Death and Dismemberment (AD&D) through the Guardian. Purchasing life insurance protects your loved ones from the potentially devastating financial losses that could result if something happened to you.

Life insurance works differently than medical, dental, and vision because it usually doesn't offer an open enrollment. The Guardian Voluntary Life has an annual election option. This option allows an employee who has elected coverage when first eligible, to annually enroll for an increase in coverage, with an electable amount up to $50,000 not to exceed the guaranteed issue amount of $200,000 for employees. This option applies to employee only.

*If you have not chosen Voluntary Life when you were eligible, you will need to complete the evidence of insurability for any amount of coverage.*

## What is Guarantee Issue?

The "guarantee" means you are not required to answer health questions to qualify for coverage up to and including the specified amount when you sign up for coverage when you are first eligible. If you decide to purchase above the guaranteed issue but aren't approved for the additional amount, you will still be able to keep up with the guaranteed issue.

The cost of life insurance is based on your age and the amount of insurance you'd like to buy. You must enroll yourself to enroll your family members. Your costs can be found through your online enrollment portal or by contacting Human Resources. For example, if an employee's age is under 30 and purchases $200k of Life and AD&D, the cost per pay period is $8.31 per check (26 pay periods).

| Benefit Coverage | Voluntary Life / AD&D |
|---|---|
| **Benefit Maximums** | |
| Employee | Purchase in increments of $10k up to a $500,000 maximum |
| Spouse/Domestic Partner | Purchase in $5,000 increments up to $250,000 maximum |
| Child(ren) | Purchase in $1,000 increments up to $10,000 maximum |
| **Guaranteed Issue** | |
| Employee | $200,000 |
| Spouse/Domestic Partner | $50,000 |
| Child(ren) | $10,000 |

## 2025-2026 Enrollment Rules & Beyond

- **New Hire Employees** – You will have a one-time opportunity to purchase up to the guaranteed issue without submitting evidence of insurability.
- **All Other Employees** – If you previously declined coverage, you will be required to submit evidence of insurability for all requested amounts.
- **Open Enrollment Rule** – If an employee enrolls (under 65) in the minimum employee benefit amount of $10,000 when you were initially eligible, you can increase your coverage during open enrollment in $10k increments, up to an additional $50k, not to exceed the $200k guarantee issue amount.
- Dependents & Spouses previously waived coverage or are requesting an increase are subject to evidence of insurability for any amount.

# Accident Plan

Guardian will provide two accident plans from which to choose. Both plans offer an annual wellness benefit of $75 per covered person.

- Low Plan – **Advantage**: costs less in a paycheck but will be reimbursed at a lower level.
- High Plan – **Premier**: costs more in a paycheck but will be reimbursed at a higher level.

No one plans to have an accident, but it can happen at any moment. Most major medical insurance plans only pay a portion of the bills. Accident insurance pays a cash benefit directly to you if you or your covered dependents are injured in an accident, even if it's not covered by your medical insurance.

Below is a chart of coverage examples to give you an idea of the difference between the Low and High plan. You can find a complete list of covered services in your online enrollment system.

| Services | Coverage Examples | |
|---|---|---|
| | Low Plan – Advantage | High Plan – Premier |
| Dislocations | Up to $2,000 | Up to $6,000 |
| Hospital Admissions | $1,000 | $1,500 |
| Concussion | $200 | $200 |
| Hospital ICU | $400/day up to 15 days | $800/day up to 15 days |
| Accidental Death / Common Carrier | 100% | 100% |

| Employee Contributions (Bi-Weekly Paycheck) | | |
|---|---|---|
| | Low Plan – Advantage | High Plan – Premier |
| Employee | $4.02 | $5.64 |
| Employee & Spouse | $6.45 | $8.98 |
| Employee & Child(ren) | $6.56 | $9.18 |
| Employee & Family | $8.99 | $12.52 |

# Critical Illness Plan

The signs pointing to a critical illness are not always clear and may not be preventable, but our coverage can help offer financial protection in the event you are diagnosed. Guardian critical illness coverage provides a lump-sum cash benefit to help you cover the out-of-pocket expenses associated with a critical illness such as: stroke, heart attack, major organ failure, cancer, end-stage kidney failure, occupational infectious disease, etc.

If you or covered family members complete a wellness screening, you can receive $50 per year, per covered person. Benefit Coverage Amounts Available:

- Employee: $5,000 to $30,000 in $5,000 increments
- Spouse: $5,000 to $30,000 in $5,000 increments up to 100% of the employee's amount
- Child(ren): 50% of the employee's amount

The cost for critical illness is based on your age. You must enroll yourself to enroll your family members. Your costs can be found through your online enrollment portal, or you can contact human resources. For example, if an employee between the ages of 25 to 29 purchases $30k, the cost per pay period is $6.09 per check (26 pay periods). Child cost is included in the employee election.

# Contacts

## Have Questions? Need Help?

Turning Point USA is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

The Specialists in the **Benefit Resource Center are available Monday through Friday 8:00am to 5:00pm Pacific & Mountain Standard Time at 866-468-7272 or via e-mail at BRCWest@usi.com.** If you need assistance outside of regular business hours, please leave a message and one of the Benefit Specialists will promptly return your call or e-mail message by the end of the following business day.

## Carrier Customer Service

Additional information regarding benefit plans can be found on the Payroll Experts website. Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

| BENEFITS PLAN | CARRIER | PHONE NUMBER | WEBSITE |
|---|---|---|---|
| Medical | BCBS of Arizona | (602) 864-4400<br>(800) 232-2345 x4197 | www.azblue.com |
| Dental | Guardian | (888) 600-1600 | www.guardianlife.com |
| Vision | Guardian | (888) 600-1600 | www.guardianlife.com |
| Voluntary Life and AD&D | Guardian | (888) 600-1600 | www.guardianlife.com |
| Short-Term Disability (STD) | Guardian | (888) 600-1600 | www.guardianlife.com |
| Accident | Guardian | (888) 600-1600 | www.guardianlife.com |
| Critical Illness | Guardian | (888) 600-1600 | www.guardianlife.com |

# REQUIRED NOTIFICATIONS

## Important Legal Notices Affecting Your Health Plan Coverage

### THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

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

| | Deductible | Coinsurance |
|---|---|---|
| Statewide 6000 HSA | $6,000 | 70% |
| Statewide 5000 PPO | $5,000 | 70% |
| Statewide 3000 PPO | $3,000 | 70% |
| Statewide 4000 HSA | $4,000 | 100% |
| Statewide 3300 HSA | $3,300 | 100% |

### NEWBORNS ACT DISCLOSURE - FEDERAL

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

### 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 enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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 30 days after marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

## STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

### Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

### Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

### Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

### Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file a suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file a suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

### Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

## CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Hailey Boomershine
United States
Hailey@tpusa.com

# Important Notice from Turning Point USA About Your Prescription Drug Coverage and Medicare

## HSA 3300, HSA 4000, PPO 3000 & PPO 5000 Plans

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Turning Point USA 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. Turning Point USA has determined that the prescription drug coverage offered by the Blue Cross Blue Shield of Arizona 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.

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**When Can You Join A Medicare Drug Plan?**
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

**What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?**
If you decide to join a Medicare drug plan, your current Turning Point USA coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Turning Point USA coverage, be aware that you and your dependents will be able to get this coverage back.

**When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?**
You should also know that if you drop or lose your current coverage with Turning Point USA and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

**For More Information About This Notice Or Your Current Prescription Drug Coverage…**
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Turning Point USA changes. You also may request a copy of this notice at any time.

| | |
|---|---|
| Date: | November 1, 2025 |
| Name of Entity/Sender: | Turning Point USA |
| Contact--Position/Office: | Hailey Boomershine |
| Address: | 4940 E. Beverly Rd; Phoenix, AZ 85044 |
| Phone Number: | 925-997-1747 |

**For More Information About Your Options Under Medicare Prescription Drug Coverage…**
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

# Important Notice From Turning Point USA About Your Prescription Drug Coverage and Medicare

## HSA 6000 Plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Turning Point USA 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three 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. Turning Point USA has determined that the prescription drug coverage offered by the Turning Point USA for the plan year 2025 is, on average for all plan participants, **NOT** expected to pay out as much as standard Medicare prescription drug coverage pays. **Therefore, your coverage is considered Non-Creditable Coverage**. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Turning Point USA Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

3. You can keep your current coverage from Turning Point USA. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully – it explains your options.

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**When Can You Join a Medicare Drug Plan?**
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

**What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?**
If you decide to join a Medicare drug plan, the following options may apply:

You may stay in the Turning Point USA and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date, but you will have to pay a higher premium (penalty) because you did not have creditable coverage.

You may stay in the Turning Point USA and also enroll in the Medicare prescription drug plan. Turning Point USA will be a primary payer for prescription drugs and Medicare Part D will be a secondary payer.

You may decline coverage in the Turning Point USA and choose to enroll in Medicare as the only payer for all medical and prescription drug expenses. If you do not enroll in the Turning Point USA Plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to status change under the cafeteria plan or a special enrollment event.

**When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?**
Since the coverage under Turning Point USA is not creditable for the plan year 2025 and depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

**For More Information About This Notice Or Your Current Prescription Drug Coverage…**
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Turning Point USA changes. You also may request a copy of this notice at any time.

| | |
|---|---|
| Date: | November 1, 2025 |
| Name of Entity/Sender: | Turning Point USA |
| Contact--Position/Office: | Hailey Boomershine |
| Address: | 4940 E. Beverly Rd; Phoenix, AZ 85044 |
| Phone Number: | 925-997-1747 |

**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).

## 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)**.

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | ALASKA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program<br>Website:<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **FLORIDA – Medicaid** |

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| Health First Colorado Website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |
| **GEORGIA – Medicaid** | **INDIANA – Medicaid** |
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: 678-564-1162, Press 2 | Health Insurance Premium Payment Program<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/<br>Family and Social Services Administration<br>Phone: 1-800-403-0864<br>Member Services Phone: 1-800-457-4584 |
| **IOWA – Medicaid and CHIP (Hawki)** | **KANSAS – Medicaid** |
| Medicaid Website: Iowa Medicaid \| Health & Human Services<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website: Hawki - Healthy and Well Kids in Iowa \| Health & Human Services<br>Hawki Phone: 1-800-257-8563<br>HIPP Website: Health Insurance Premium Payment (HIPP) \| Health & Human Services (iowa.gov)<br>HIPP Phone: 1-888-346-9562 | Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884<br>HIPP Phone: 1-800-967-4660 |
| **KENTUCKY – Medicaid** | **LOUISIANA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br>KCHIP Website: https://kynect.ky.gov<br>Phone: 1-877-524-4718<br>Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms | Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) |
| **MAINE – Medicaid** | **MASSACHUSETTS – Medicaid and CHIP** |

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| Enrollment Website:<br>https://www.mymaineconnection.gov/benefits/s/?language=en_US<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-977-6740<br>TTY: Maine relay 711 | Website: https://www.mass.gov/masshealth/pa<br>Phone: 1-800-862-4840<br>TTY: 711<br>Email: masspremassistance@accenture.com |
| **MINNESOTA – Medicaid** | **MISSOURI – Medicaid** |
| Website:<br>https://mn.gov/dhs/health-care-coverage/<br>Phone: 1-800-657-3672 | Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 |
| **MONTANA – Medicaid** | **NEBRASKA – Medicaid** |
| Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084<br>Email: HHSHIPPProgram@mt.gov | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **NEVADA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 | Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext. 15218<br>Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov |
| **NEW JERSEY – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Phone: 1-800-356-1561<br>CHIP Premium Assistance Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 (TTY: 711) | Website:<br>https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **NORTH CAROLINA – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 | Website: https://www.hhs.nd.gov/healthcare<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **OREGON – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://healthcare.oregon.gov/Pages/index.aspx<br>Phone: 1-800-699-9075 |

| PENNSYLVANIA – Medicaid and CHIP | RHODE ISLAND – Medicaid and CHIP |
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| Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or<br>401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Utah's Premium Partnership for Health Insurance (UPP)<br>Website: https://medicaid.utah.gov/upp/<br>Email: upp@utah.gov<br>Phone: 1-888-222-2542<br>Adult Expansion Website:<br>https://medicaid.utah.gov/expansion/<br>Utah Medicaid Buyout Program Website:<br>https://medicaid.utah.gov/buyout-program/<br>CHIP Website: https://chip.utah.gov/ |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website:<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br><br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

**Paperwork Reduction Act Statement**

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

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

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

# New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 8-31-2023)

## PART A: General Information

When key parts of the health care law take effect in 2014, there will be 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. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% 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 _____.

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

[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.

# PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

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|---|---|---|
| 3. Employer name<br>Turning Point USA | 4. Employer Identification Number (EIN)<br>80-0835023 | |
| 5. Employer address<br>4940 E. Beverly Road | 6. Employer phone number<br>(602) 921-6934 | |
| 7. City<br>Phoenix | 8. State<br>AZ | 9. ZIP code<br>85044 |
| 10. Who can we contact about employee health coverage at this job?<br>Hailey Boomershine | | |
| 11. Phone number (if different from above) | 12. Email address<br>Hailey@tpusa.com | |

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☒ Some employees. Eligible employees are:
    Employees working 30 or more hours per week
- With respect to dependents:
  - ☒ We do offer coverage. Eligible dependents are:
    Your legal spouse, domestic partner and children up to the age of 26
  - ☐ We do not offer coverage.

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

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

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

* An employer – sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36 B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)


This brochure summarizes the benefit plans that are available to Turning Point USA. eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Capital Department. The information provided in this brochure is not a guarantee of benefits.