



2026

Employee Benefits Guide



EFFECTIVE JANUARY 1, 2026

Table of Contents

Welcome	3
Eligibility	4
Benefit Glossary	5
Medical Plans	6
Health Savings Account (HSA)	8
Dental Plan	9
Vision Plan Overview	10
Benefit Plan Costs	11
Flexible Spending Account (FSA)	12
Life and Disability	14
Optional Life and AD&D	15
Voluntary Worksite Benefits	16
Hospital Indemnity Insurance	17
Critical Illnesses Insurance	18
Accident Insurance	19
EAP	20
401(k) Plan	21
Paid Time Off and Leaves	22
Volunteer Program	24
Contacts and Resources	25
Notices, Special Rights and Privacy	26
Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)	27
Medicare Part D Creditable Coverage Notice	31
Medicare Part D Non-Creditable Coverage Notice	33
Health Insurance Marketplace Coverage Options and Your Health Coverage	35
Notice Of Privacy Practices	40

Welcome

At Otak, our primary focus is on providing our valued team members with a benefits package tailored to meet your unique needs. We recognize the significance of a well-rounded benefits program, and as a testament to our commitment, we offer an extensive array of plans to ensure the well-being of both you and your family. This Employee Benefits Guide is your reliable resource for all matters concerning your benefits.

We hold in high regard the commitment and effort that our team members bring to work every day. To express our gratitude, we've developed a comprehensive and cost-effective benefits package. If you have questions or need further information on your benefits, we encourage you to refer to the plan documents or reach out to our dedicated People Services Team. We're here to support you every step of the way and ensure that your well-being remains our utmost priority.

Sincerely,



This Guide provides highlights of the benefit plans offered to you by Otak, and in no way serves as the actual plan description or plan document. Certain restrictions and exclusions apply. For exact terms and conditions, please refer to the Plan Document, Contract or the Summary of Benefits & Coverage (SBC). The plan documents will always govern the benefits that Otak provides for you. Otak reserves the right to modify any or all of these plans at any time. Please see People Services for more information. The information provided in this Guide is advisory and is provided for general informational purposes only. This information should not be considered legal or tax advice or opinion on any specific facts or circumstances. Readers and participants are urged to consult their legal counsel and/or tax advisor concerning any legal or tax questions that may arise.

Eligibility

Regular employees working a minimum of 30 hours per week are eligible for benefits. Benefits begin on the first of the month following date of hire. Eligible dependents are also able to enroll in the medical, dental, vision and voluntary plans. Eligible dependents include your spouse or domestic partner, your children, and your spouse's or domestic partner's children. Dependent children are eligible for coverage on the medical, dental and vision plans through the last day of the month of their 26th birthday. Their coverage in the voluntary plans will end on their birthday.

Enrollment Opportunities

You are eligible to enroll in the available plans and/or make plan changes as follows:

1. During your initial eligibility period (when your employment with Otak begins).
2. With a qualifying life event during the plan year such as marriage, divorce, birth or adoption of a child, or a spouse/domestic partner losing or gaining other coverage.*
3. The annual open enrollment period, which is held annually in November, for a January 1st effective date.

To enroll or make changes, you must complete online enrollment within 31 days of your eligibility date through the Benefits Enrollment Portal in ADP.

* If you have a qualifying event change, you must notify People Services within 30 days of the change or you forfeit your opportunity to make changes and must wait until the next open enrollment.

When Coverage Ends

Your benefit plan participation and the participation of your eligible dependents will terminate on the last day of the month in which you terminate employment with Otak. For Life, Disability, Voluntary Plans, FSA and Commuter benefits will end on the last day of employment. Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below the eligibility hours requirement, and/or if you submit false eligibility or claims information.



Benefit Glossary

The following definitions should help you to better understand your benefit plans. Remember, you have access to In-Network and Out-of-Network providers. Our Medical, Dental, and Vision network providers have contracted rates that can be much lower than Out-of-Network providers. Your out-of-pocket expense may be lower by using In-Network providers.

Co-Insurance

The percentage of cost-sharing between what you and the insurance company must pay, after any applicable deductible has been met.

Co-Pay

The set dollar amount that you must pay to a provider when services are rendered.

Deductible

The amount you pay before co-insurance is paid. You only need to meet your deductible once per calendar year.

Network

The group of providers who are approved for services and are available for treatment under the insurance company's contract.

Outpatient

A patient who receives treatment at a hospital or outpatient facility without being admitted overnight.

Out-of-Pocket-Maximum

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Provider

Any facility, person, or entity recognized for payment by the insurance company.

Usual, Customary and Reasonable (UCR)

The determined going rate for like services in the same area. The insurance company's coinsurance percentage that they pay is taken from the UCR amount for that service. You are responsible for your co-insurance percentage plus all of the amount that exceeds UCR. UCR is used only when services are provided by an Out-of-Network provider.

Medical Plans



Regence PPO Plan		
Plan Features	In-Network	Out-of-Network
Calendar Year Deductible	\$750 individual \$1,500 family	\$2,000 individual \$4,000 family
Out-Of-Pocket Maximum	\$3,000 individual \$6,000 family	\$7,250 individual \$14,500 family
Physician Services (Per Visit)		
Office Visits	\$5 (no deductible) first three visits, then \$35 (no deductible)	40% (after deductible)
Specialist Visits	\$60 (no deductible)	40% (after deductible)
Routine Preventive Care	Covered in full	40% (after deductible)
Lab/X-ray	20% (no deductible)	40% (after deductible)
CT,MRI,PET,SCN,EKG	20% (after deductible)	40% (after deductible)
Out-Patient Rehabilitation	\$60 (no deductible); 25 visits per calendar year	40% (after deductible)
Chiropractic	\$35 (no deductible); 25 visits combined per member per calendar year	40% (after deductible) of allowed amount and balance of billed charges; 25 visits combined per member per calendar year
Acupuncture	\$35 (no deductible); 25 visits per member per calendar year	40% (after deductible) of allowed amount and balance of billed charges; 25 visits per member per calendar year
Hospital Services		
Inpatient Admission	20% (after deductible)	40% (after deductible)
Outpatient Surgery	10% (after deductible) at an ambulatory surgery center, 20% (after deductible) at all other facilities	40% (after deductible)
Emergency Services		
Emergency Room	20% after \$300 copay (no deductible)	
Urgent Care Facility	\$35 (no deductible)	40% (after deductible)
Pharmacy Benefit		
Preferred Generic	\$3	
Generic	\$10	
Preferred Brand	\$30	
Non-Preferred Brand	\$60	
Specialty	25% up to \$125	
Non-Preferred Specialty	30% up to \$250	
Mail Order and Retail 90	2x copay for 90 day supply	

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Medical Plans



Regence HDHP/HSA Plan		
Plan Features	In-Network	Out-of-Network
Calendar Year Deductible	\$3,400 individual \$6,000 family*	\$6,800 individual \$12,000 family
Out-Of-Pocket Maximum	\$6,000 individual \$12,000 family**	\$12,000 individual \$18,000 family**
Physician Services (Per Visit) All services subject to deductible except for preventive care		
Office/Specialists Visits	The first 3 visits are covered in full after deductible; then 20% All Other Office Visits: 20%	40% (after deductible)
Routine Preventive Care	Covered in full	40% (after deductible)
Lab/X-ray	20% (after deductible)	40% (after deductible)
CT,MRI,PET,SCN,EKG	20% (after deductible)	40% (after deductible)
Out-Patient Rehabilitation	20% (after deductible); 25 visits per calendar year	40% (after deductible)
Chiropractic	20% (after deductible); 25 visits combined per member per calendar year	20% (after deductible) of allowed amount and balance of billed charges; 25 visits combined per member per calendar year
Acupuncture	20% (after deductible); 25 visits per member per calendar year	20% (after deductible) of allowed amount and balance of billed charges; 25 visits per member per calendar year
Hospital Services		
Inpatient Admission	20% (after deductible)	40% (after deductible)
Outpatient Surgery	10% (after deductible) at an ambulatory surgery center, 20% (after deductible) at all other facilities	40% (after deductible)
Emergency Services		
Emergency Room	20% (after deductible) of the allowed amount	20% (after In-Network Deductible) of the allowed amount.
Urgent Care Facility	20% (after deductible) of the allowed amount	40% (after deductible) of the allowed amount and the balance of billed charges
Pharmacy Benefit		
Preferred Generic	\$3	
Generic	\$15	
Preferred Brand	\$45	
Non-Preferred Brand	\$75	
Specialty	25% up to \$150	
Non-Preferred Specialty	30% up to \$250	
Mail Order and Retail 90	2x copay for 90 day supply	

*\$3,400 Individual Embedded Deductible

** \$6,000 Individual Embedded Out of Pocket Maximum

Health Savings Account (HSA)

What is it?

A health savings account, also known as an HSA, is a tax-exempt savings account that, when paired with a qualified high-deductible health plan (QHDHP), can be used to pay for certain medical expenses. Funds deposited are not taxed, nor are withdrawals for qualified expenses. When you enroll in the HSA Qualified Medical Plan you will also have an HSA account through **Health Equity**.

Am I Eligible?

You are eligible for an HSA as long as you:

- Are enrolled in a qualified high-deductible health plan (HDHP)
- Are not covered by any other medical plan, except what is permitted by the IRS
- Are not enrolled in Medicare
- Cannot be claimed as a dependent on another individual's tax return
- Are not enrolled in a general-purpose health flexible spending account (FSA) (and neither is your spouse)

How do I Use it?

An HSA bank account's primary purpose is to help pay for any eligible out-of-pocket expenses you may incur related to your own or your eligible dependents health care needs now or in the future. You will have the option to use a debit card that can be used to pay for qualified medical expenses either at the time of service or after a bill has been received. You also have the option to reimburse yourself for expenses that are not paid for with your HSA debit card.

Contributions?

Otak will contribute to your HSA account in the amount of \$1,000 per year for individual coverage or \$1,500 per year for employee plus dependent(s) coverage. In addition, employees may make pre-tax payroll contributions up to the IRS maximum.

2026 Contribution limits:

- Employee only - \$4,400 per year
- Employee + Dependent(s) - \$8,750 per year
- Employees 55 and older an additional catch-up contribution of \$1,000 per year is allowed

100% of any unused funds rollover year-after-year, and the account is portable, which means you can take the account with you, even if you switch employers. You also have the option to invest the money in your HSA into select mutual funds.

Dental Plan



Otak provides comprehensive dental coverage through Moda/Delta Dental of Oregon. You have the choice to see in and out-of-network providers. However, if you obtain services from a Moda/Delta Dental Network Provider, you will save money on your out-of-pocket expenses, and your annual maximum benefit will go further.

2026 PPO Dental Highlights	In-Network PPO Provider	In-Network Premier Provider	Out-of-Network
Annual Deductible Annual	\$50 Deductible \$150 Family		
Maximum Benefit Fees	\$1,500 Per Member Per Calendar Year		
Based On	Benefits are paid at the PPO benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental PPO fee).	Benefits are paid at the Premier benefit level. Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).	Benefits are paid at the Out of Network benefit level. Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.
	Plan Pays:	Plan Pays:	Plan Pays:
Preventive - Class 1 Such as: Exams, Cleaning, X-Rays, Sealants, Fluoride	100% Deductible Waived	100% Deductible Waived	100% Deductible Waived
Basic Services - Class 2 Such as: Fillings, Oral Surgery, Endodontics, Periodontics	100% After Deductible	100% After Deductible	100% After Deductible
Major Services Such as: Implants, Crowns, Dentures, Bridges	60% After Deductible	60% After Deductible	60% After Deductible
TMJ Services	60% After Deductible (up to a \$1,000 lifetime max. per person)	60% After Deductible (up to a \$1,000 lifetime max. per person)	60% After Deductible (up to a \$1,000 lifetime max. per person)
Orthodontia Benefit	50% After Deductible (up to a \$1,000 lifetime max. per person)	50% After Deductible (up to a \$1,000 lifetime max. per person)	50% After Deductible (up to a \$1,000 lifetime max. per person)

PROVIDER FINDER Go to: www.modahealth.com Or call: 1.888.217.2365

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Vision Plan Overview



Otak provides vision benefits directly through VSP. You have the choice to see in and out-of-network providers. However, if you obtain services from a VSP Network Provider, you will save money on your out-of-pocket expenses, and your benefit will go further.

Vision Highlights	In-Network	Out-of-Network
Exam Once every 12 months	\$20 Copay Routine Retinal Screening: up to \$39 Copay	Reimbursed up to \$45
Standard Lenses Once every 12 months	\$20 Copay	Reimbursed up to \$30-\$100
Frames Once every 12 months	\$225 Allowance 20% Off Remaining Balance	Reimbursed up to \$70
Elective contact Lenses Once every 12 months	\$60 Maximum Copay Fitting \$200 Contacts Allowance	Reimbursed up to \$105

Enrollees in Otak's VSP plan can easily use their coverage at any one of VSP's broad network of providers – no ID card required! Just tell the provider that you have VSP insurance, and they'll find your coverage electronically.

Extra Savings & Discounts

- **VSP In-Network Frame Discount:** 20% discount off the remaining balance in excess of the frame allowance.
- **Additional Glasses & Sunglasses:** 20% off from any VSP doctor within 12 months of your last WellVision Exam.
- **Laser Vision Correction:** 15%-20% off the regular price; discounts only available from contracted facilities.

PROVIDER FINDER Go to: www.vsp.com Or call: 1.800.877.7195

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Benefit Plan Costs

Medical	
Regence PPO Plan	
TIER	EMPLOYEE PER PAYCHECK
Employee Only	\$0.00
Employee and Spouse	\$247.65
Employee and Child(ren)	\$232.00
Family	\$374.21
Regence HDHP/HSA Plan	
TIER	EMPLOYEE PER PAYCHECK
Employee Only	\$0.00
Employee and Spouse	\$176.13
Employee and Child(ren)	\$164.99
Family	\$266.12

Dental	
Delta Dental Plan	
TIER	EMPLOYEE PER PAYCHECK
Employee Only	\$0.00
Employee and Spouse	\$10.57
Employee and Child(ren)	\$13.22
Family	\$20.06

Vision	
VSP Vision Plan	
TIER	EMPLOYEE PER PAYCHECK
Employee Only	\$0.00
Employee and Spouse	\$2.15
Employee and Child(ren)	\$2.20
Family	\$3.54

*Employees who have other qualifying medical insurance, that waive enrollment in Otak's Medical plan, will receive a \$50 bonus each paycheck.

Flexible Spending Account (FSA)



Otak offers Healthcare, Dependent Care and Commuter Flexible Spending Accounts (FSA's) through WEX. By participating in the FSA plans, you can use pre-tax dollars to reimburse yourself for a wide variety of health, dependent care and commuting/parking for work expenses. This decreases your taxable income, and therefore reduces your Federal income and Social Security taxes. The amount you elect to contribute to each account will be divided into equal amounts and deducted from your paycheck before federal, state and local income taxes are withdrawn.

YOU MUST RE-ENROLL IN THESE BENEFITS EVERY YEAR. Otak PAYS THE COST FOR ADMINISTRATION.

Healthcare FSA

Out-of-pocket healthcare expenses for yourself and/or your dependents - such as medical, dental and/or vision deductibles, coinsurance, and copays - are eligible for reimbursement from your Healthcare FSA.

2026 ANNUAL MAXIMUM HEALTHCARE CONTRIBUTION IS \$3,400

Dependent Care FSA

Expenses for dependent care services for children under age 13, a disabled spouse, or an incapacitated parent are eligible for reimbursement from your Dependent Care FSA as long as you incur them while you and your spouse work or attend school full-time.

2026 ANNUAL MAXIMUM DEPENDENT CARE CONTRIBUTION IS \$7,500. (\$3,750 IF MARRIED AND FILING A SEPARATE TAX RETURN)

Commuter FSA

Allows you to set aside pre-tax dollars to pay for expenses related to commuting to and from work for mass transit, vanpooling and work-related parking costs. This includes transit passes, tokens, fare cards, vouchers, parking passes and more.

2026 CONTRIBUTION MAXIMUM IS \$340 PER MONTH FOR TRANSIT OR PARKING EXPENSES

FSA Rules and Regulations

Plan your annual healthcare FSA contribution amounts carefully; the election you make when you enroll is binding for the entire plan year unless you have a qualifying status change. Additionally, the IRS imposes some rules and restrictions on the way you can use FSA funds.

- You must incur eligible expenses during the plan year, January 1st – December 31st.
- You have 90 days from the last day of the plan year to submit your expenses for reimbursement.
- At the end of the plan year, you may roll over up to \$TBD in unused deductions for use in the following contract year. You will forfeit any remaining balance over \$660.
- You cannot transfer money from one account to another; money in your Healthcare FSA cannot be used for dependent care expenses, and money in your Dependent Care FSA cannot be used for healthcare expenses.
- You may only make changes to your healthcare contribution amounts with a qualified status change: marriage, divorce or legal separation, death of a spouse or dependent, change from part-time to full-time or full-time to part-time employment, termination or commencement of spouse employment, significant change in health coverage due to spouse's employment. Dependent care and commuter contributions can be changed throughout the year.

If you enroll in the HSA plan, you are not eligible for the Healthcare FSA plan.

Filing a Claim for Reimbursement is Easy

Be sure that you have the necessary claims documentation to include date of service, provider, type of expense and out-of-pocket cost.

Debit Card: Request a FSA Debit Card and use the Debit Card to pay for FSA eligible expenses at point of sale. When using the Debit Card feature please note that you will need to keep, and may be asked to provide, documentation of the claim.

Online Claims Submission: <https://benefitslogin.wexhealth.com> Upload your claim documentation, complete the online wizard, and reimbursement will be sent to you within days.

Paper Claims Submission: Download the claim form from the WEX Benefits website, and submit via mail or fax along with your claim documentation.

Life and Disability



EMPLOYER PAID TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Eligible employees of Otak are automatically enrolled in Life/AD&D insurance on the first of the month following date of hire. This benefit is paid for by Otak and provided through Unum. The life insurance benefit pays your designated beneficiary(ies). The benefit is doubled if your death is the result of an accident. Benefits are also payable in the case of dismemberment. See contract for benefit details and exclusions.

LIFE / AD&D	
Employee Amount	1 - 1/2 times your annual earnings, up to \$250,000
Maximum Amount	\$250,000
Reductions	Reduces by 35% at age 65 Reduces by 50% at age 70

DISABILITY AND FAMILY MEDICAL LEAVE

Eligible employees of Otak are automatically enrolled in Short-Term and Long-Term Disability Insurance on the first of the month following your date of hire. These benefits are paid for by Otak and provided by Unum. Because these benefits are employer paid, any disability benefits payable to you will be taxable.

SHORT TERM DISABILITY (STD)	LONG TERM DISABILITY (LTD)
STD insurance can help replace a portion of your income during the initial weeks of Disability.	LTD insurance helps replace a portion of your income during an extended Disability
ELIMINATION PERIOD: If you are disabled, your elimination period, which is 7 days, will need to be satisfied before benefits will begin.	ELIMINATION PERIOD: If you are disabled, your elimination period, which is 90 days, will need to be satisfied before benefits will begin.
WEEKLY BENEFIT: Once you have satisfied your elimination period, benefits can be paid up to 60% of your pre-disability earnings, up to \$1,500 maximum per week.	MONTHLY BENEFIT: Once you have satisfied your elimination period, benefits can be paid up to 50% of your pre-disability earnings, to a \$10,000 monthly maximum.
BENEFIT DURATION: Benefits will be paid for a maximum of 12 weeks.	BENEFIT DURATION: Benefits will be paid up to your Social Security Normal Retirement Age (SSNRA) for a disability starting before the employee reaches 60 and reduced if over 60.

STATE FAMILY AND MEDICAL LEAVE

For employees working in Oregon or Colorado, Otak has opted to offer mandatory state paid Family and Medical Leaves with an equivalent plan through our current disability carrier, Unum. For those employees that work in Washington, any Unum Short Term Disability plan payments will be offset by any payments provided under the WA PFML.

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Optional Life and AD&D



Eligible employees may purchase additional Life and AD&D insurance through Unum at your own cost via payroll deduction. Coverage may also be purchased for your spouse/domestic partner and/or your dependent child(ren). Life benefits are available up to the guarantee issue amount at your initial eligibility period. All life elections over the guarantee issue amount, and late applicants, will be subject to health underwriting and carrier approval.

EMPLOYEE	SPOUSE OR DOMESTIC PARTNER	CHILD AGE 14 DAYS – 26 YEARS
LIFE & AD&D BENEFIT OPTIONS Increments of \$10,000 Up to \$500,000 Maximum	LIFE & AD&D BENEFIT OPTIONS Increments of \$5,000 Up to \$150,000 Maximum	LIFE & AD&D BENEFIT OPTIONS Increments of \$2,000 Up to \$10,000 Maximum
GUARANTEE ISSUE Amounts Up to \$150,000	GUARANTEE ISSUE Amounts Up to \$25,000	GUARANTEE ISSUE Amounts Up to \$10,000

OPTIONAL TERM LIFE-MONTHLY RATES			
Rate is based on attained age, Updated annually on January 1st	Employee Monthly Rate Per \$10,000 of Coverage	Spouse Monthly Rate Per \$5,000 of Coverage	Child Monthly Rate Per \$2,000 of Coverage
Age 15-34	\$0.570	\$0.285	\$0.334
Age 35-39	\$0.760	\$0.380	
Age 40-44	\$1.150	\$0.575	
Age 45-49	\$1.830	\$0.915	
Age 50-54	\$2.800	\$1.400	
Age 55-59	\$4.710	\$2.355	
Age 60-64	\$7.830	\$3.915	
Age 65-69	\$12.530	\$6.265	
Age 70-74	\$21.290	\$10.645	
Age 75+	\$37.810	\$18.905	
OPTIONAL AD&D - MONTHLY RATES			
	Employee Monthly Rate Per \$10,000 of Coverage	Spouse Monthly Rate Per \$5,000 of Coverage	Child Monthly Rate Per \$2,000 of Coverage
	\$0.350	\$0.175	\$0.070

Formula to calculate your cost for this benefit: Above rate x Elected Benefit Amount / 10,000 = Monthly Employee Cost. Please see the plan SPD or Summary for actual benefits, details, limitations and exclusions.



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Voluntary Worksite Benefits

OPTIONAL CRITICAL ILLNESS, ACCIDENT, AND HOSPITAL INDEMNITY

Eligible employees may purchase optional insurance through Unum at your own cost via payroll deduction. The products are available individually. All the products are guaranteed issue and don't require you to answer any medical questions in order to enroll once you are first eligible. The premiums vary and some are based on your age at the time of issue and others on your age band. The insurance is portable up through age 70 and can be taken with you if your employment has ended and are paid on a direct basis with Unum.

Note: A pre-existing condition limitation applies and includes any condition for which an employee consults with a physician, receives treatment, or takes prescribed drugs for a condition within 3 months prior to the policy effective date and will be excluded for the first 12 months of the policy.

PER PAYCHECK COST - UNUM VOLUNTARY

Cost will vary depending on your election and age. See Benefit Enrollment Portal for more details.

Critical Illness Insurance

Critical Illness Insurance is designed to help employees offset the financial effects of a catastrophic illness with a lump sum benefit if an insured is diagnosed with a covered critical illness (including cancer). The critical illness benefit is based on the amount of coverage in effect on the date of diagnosis of a critical illness or the date treatment is received according to the terms and provisions of the policy.

Accident Insurance

If you have an active family, you know that accidents happen. For every covered incident, Accident Insurance pays a benefit based on the injury and various treatments and/or services received, regardless of what is covered by medical insurance. Lump sum benefits are paid directly to the employee based on the amount of coverage listed in a schedule of benefits. The accident base plan is guaranteed issue, so no health questions are required.

Hospital Indemnity Insurance

Hospital indemnity insurance is designed to help provide financial protection for covered individuals by paying a benefit due to a hospitalization and in some cases, for treatment received for an accident or sickness, even if that treatment occurs outside the hospital. Employees can use the benefit to meet the out-of-pocket expenses and extra bills that can occur. Lump sum benefits are paid directly to the employee based on the amount of coverage listed, regardless of the actual cost of treatment. Note: If enrolling outside your initial eligibility period, you will need to complete a medical questionnaire and be approved for coverage.

Be Well Benefit

Employees who enroll in Unum's Voluntary Worksite Benefits can receive a valuable annual incentive for completing important tests, screenings and immunizations through Unum's Be Well Benefit. Many of these tests are routinely performed, so it's easy to take advantage of this benefit. The minimum annual benefit is \$50 per covered member per line of coverage and the Be Well benefit on your Critical Illness is tied to the coverage amount you choose. See Benefit Plan Descriptions for more information.

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Hospital Indemnity Insurance



Group Hospital Insurance can pay benefits that help you with the costs of a covered hospital visit.

HOW DOES IT WORK?

Group Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth.

WHY IS THIS COVERAGE SO VALUABLE?

- The money is payable directly to you — not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.
- You get accessible rates when you buy this coverage at work.
- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire. You'll be billed directly.

HOW MUCH DOES IT COST?

YOUR MONTHLY PREMIUM	
You	\$15.28
You and your spouse	\$30.76
You and your children	\$21.51
Family	\$36.99

WHO CAN GET COVERAGE?	
You:	If you're actively at work.
Your spouse:	Can get coverage as long as you have purchased coverage for yourself.
Your children:	Dependent children newborn until their 26th birthday, regardless of marital or student status

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage.

Coverage may vary by state. See exclusions and limitations.
This plan has a pre-existing condition limitation. See the disclosures for more information.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at <https://www.medicare.gov/publications/02110-medigap-guide-healthinsurance.pdf>

Critical Illness Insurance



HOW DOES IT WORK?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

WHY SHOULD I BUY COVERAGE NOW?

It's more accessible when you buy it through your employer and the premiums are conveniently deducted from your paycheck.

WHY IS THIS COVERAGE SO VALUABLE?

- The money can help you pay out-of-pocket medical expenses, like deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

WHO CAN GET COVERAGE?		WHAT'S COVERED?	
You:	Choose \$10,000, \$20,000 or \$30,000 of coverage with no medical underwriting to qualify if you apply during this enrollment.	Critical Illnesses • Heart attack • Stroke • Major organ failure • End-stage kidney failure • Sudden cardiac arrest • Coronary artery disease • Major (50%): Coronary artery bypass graft or valve replacement • Minor (10%): Balloon angioplasty or stent placement	
Your spouse:	Spouses can only get 50% of the employee coverage amount as long as you have purchased coverage for yourself.	Cancer conditions • Invasive cancer — all breast cancer is considered invasive • Non-invasive cancer (25%) • Skin cancer — \$500	
Your children:	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome, spina bifida, type 1 diabetes, sickle cell anemia and congenital heart disease. The diagnosis must occur after the child's coverage effective date.	Progressive Diseases • Amyotrophic Lateral Sclerosis (ALS) • Dementia, including Alzheimer's disease • Multiple Sclerosis (MS) • Parkinson's disease • Functional loss • Huntington's Disease • Lupus • Muscular Dystrophy • Myasthenia Gravis • Systemic Sclerosis (Scleroderma) • Addison's Disease	Supplemental Conditions • Loss of sight, hearing or speech • Benign brain tumor • Coma • Permanent Paralysis • Occupational HIV, Hepatitis B, C or D • Occupational PTSD Paid at 25% • Infectious Diseases • Pulmonary Embolism • Transient Ischemic Attack (TIA) • Bone Marrow/Stem Cell

Benefits may be subject to a pre-existing condition provision

Please refer to the certificate for complete definitions of these covered conditions. Coverage may vary by state. See exclusions and limitations

Accident Insurance



HOW DOES IT WORK?

Accident Insurance provides a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur off the job. And it includes a range of incidents, from common injuries to more serious events.

WHY IS THIS COVERAGE SO VALUABLE?

It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles. You'll have base coverage without medical underwriting. The cost is conveniently deducted from your paycheck.

HOW MUCH DOES IT COST?

YOUR MONTHLY PREMIUM	
You	\$9.86
You and your spouse	\$17.87
You and your children	\$26.25
Family	\$34.26

WHO CAN GET COVERAGE?	
You:	If you're actively at work.*
Your spouse:	Can get coverage as long as you have purchased coverage for yourself.
Your children:	Dependent children newborn until their 26th birthday, regardless of marital or student status

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. See Schedule of benefits for a complete listing of what is covered.



EMPLOYEE ASSISTANCE PLAN (EAP)

The LifeBalance EAP is a FREE and CONFIDENTIAL benefit provided by Otak through Unum and Integrated Behavioral Health. The EAP is available to all benefit eligible employees to help assist you and your immediate family members manage life's daily challenges – ranging from personal relationships to legal and financial resources. Get help with and find resources for things like:

- Stress, depression, anxiety
- Relationship issues, divorce
- Anger, grief and loss
- Job stress, work conflicts
- Family and parenting problems
- Childcare
- Elder care
- Identity theft
- Legal questions
- Financial services, credit report issues, debt management
- And more!

Personal Consultation with an EAP Professional

- Unlimited FREE telephonic consultation with an EAP counselor available 24/7.
- Referrals to local counselors – up to 3 sessions free of charge.

Education and additional resources are available online.



Phone: 1-800-854-1446

Available 24 hours a day. 7 days a week



Web: unum.com/lifebalance



This summary provides an outline of major benefits. This information is subject to change. In case of any discrepancies between this information and the actual plan documents, the actual plan documents will prevail.

401(k) Plan



401(K) RETIREMENT PLAN

Otak has established a 401(k) plan to help you prepare for your financial future. This benefit allows you to defer a portion of your eligible compensation to your 401(k) retirement account. Contributions and any earnings on contributions are tax deferred until money is withdrawn, subject to federal law and plan guidelines.

2026 Standard Employee Contribution (under age 50)	\$24,500
2026 Standard "Catch-Up" Contribution (age 50 and older)	\$8,000
2026 Special "Super Catch-Up" Contribution (ages 60-63)	\$11,250

If you earned more than \$145,000 from Otak in 2025 (increasing to \$150,000 for 2026), any catch-up contributions must be made as after-tax Roth contributions.

Following are highlights of our 401(k) plan. See People Services for more information:

Eligibility

You must be 18 years of age and complete one day of service to be eligible. Eligible employees may enroll immediately after their first payroll. However, you will not be eligible to participate in the Plan if you are an on-call employee, such as an intern or if you are not regularly scheduled to work at least 20 hours per week.

Employee Contribution Limits

Annual contribution limits for 401(k) plans are set by the IRS. The limit will include a base amount you can contribute plus a "catch-up" contribution for those age 50 or older. The limit is only for your contribution to the plan, and does not include Otak's matching contribution. If you have multiple employers during the year, these limits are combined for all plans to which you contribute during the year.

Contribution Changes

You may change the amount of your contribution at any time. You may also stop your contribution entirely at any time. Contact Empower to make changes to your elections.

Employer Contributions

Otak has a discretionary matching contribution. Currently, the company match is **50% of the first 6% of your bi-weekly** compensation that you contribute to the plan.

*Note: Because matching contributions are calculated on a **bi-weekly basis**, if you reach the IRS annual contribution limit early in the year by making large ("front-loaded") contributions, you may stop receiving employer match once your contributions end.*

Vesting

Your contributions are 100% vested immediately, as are your employer's match and profit-sharing contributions.

Rollover Contributions

If you have an outside qualified retirement plan or account such as a 401(k), 403(b), 457(b) or IRA, you may be able to transfer that account into your Otak 401(k) plan. Please contact People Services for additional information.

Paid Time Off and Leaves

PAID TIME OFF (PTO)

It is important that employees take time away from work to refresh and connect with family and friends, and as such, we encourage all Otak employees to use their PTO. Paid time off (PTO) is a flexible bank of leave that employees may use for their personal needs including vacation, Time Off, personal or family illness or other needs which may arise. Employees accrue PTO based on length of professional experience and number of hours worked per week. Regular, Full-time employees accrue PTO at the following rates:

EXPERIENCE	ANNUAL PTO	ACCRUAL PER PAY PERIOD
0-4 Years	15 Days	4.62 Hours
5-9 Years	17 Days	5.24 Hours
10-14 Years	19 Days	5.86 Hours
15+Years	20 Days	6.16 Hours

Part-time employees regularly working 20 or more hours per week will accrue PTO at a prorated rate proportionally based on scheduled work hours. Part-time employees regularly working less than 20 hours per week are not eligible for PTO and instead accrue paid Sick Leave.

Jury Duty

Otak provides up to 5 days of paid leave for mandatory jury duty or required court appearances as a witness as a result of a subpoena or court order.

Bereavement Leave

We understand that losing a loved one is a difficult and emotional experience. To support our team members through this difficult time, Otak provides paid Bereavement Leave based on the relationship to the family member who has passed away.

- **Spouse, domestic partner, or child:** Employees may take up to five **(5) paid working days**.
- **All other covered family members:** Employees may take up to three **(3) paid working days**.

Bereavement Leave may be taken as a continuous block or intermittently, as long as all paid leave is used within 60 days of the family member's death. With supervisory approval, employees may request additional time using PTO or unpaid time.

In some states employees may be entitled to additional unpaid leave for bereavement. Please contact People Services for more information.

Family and Medical Leaves/Military Leaves

Employees may be entitled to state paid leave due to medical or family care reasons or related to military service. Otak provides leaves of absence in accordance with applicable federal, state, and local laws and participates in applicable state leave programs:

- Paid Leave Oregon
- Colorado FAMLI
- Washington Paid Family and Medical Leave

This summary provides an outline of major benefits. This information is subject to change. In case of any discrepancies between this information and the actual plan documents, the actual plan documents will prevail.

Eligibility, duration, pay or benefits available during leave, and other requirements vary based on the type of leave, the employee's work location, and applicable law. Employees who need a leave of absence should contact People Services for information about available leave options, eligibility, and the steps required to request leave.

If you work in:	File your claim with:	Notes:
Oregon or Colorado	Unum	Unum administers both Otak's Short-Term/ Long-Term Disability plan and the state equivalent paid leave program.
Washington	Washington Paid Family & Medical Leave Program	File your claim directly with the state program. **If your leave qualifies for Short-Term Disability benefits, file a claim with Unum too.
Other States	Unum (if applying for Short-Term Disability)	If your leave qualifies for Short-Term Disability benefits, file a claim with Unum.

Holidays

Eligible employees will receive 8 paid holidays throughout the year. Otak's current observed holidays are below:

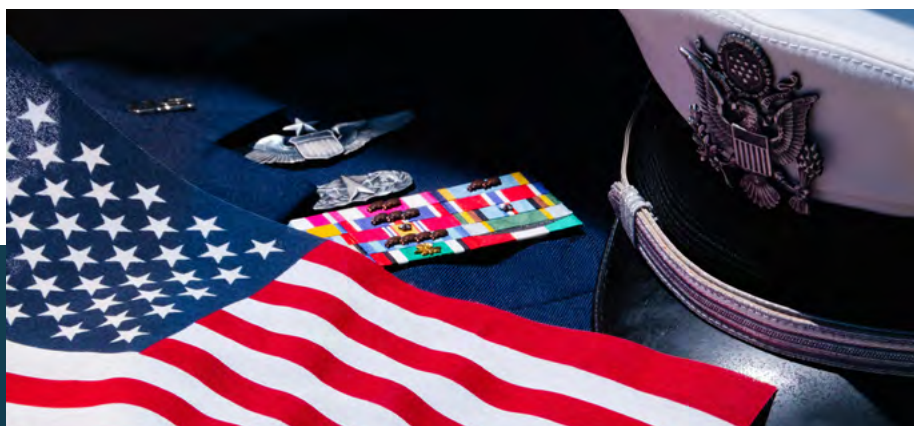
- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Day After Thanksgiving
- Christmas Eve
- Christmas Day

In addition to the above holidays, eligible employees will also receive one flex day per calendar year to use at their discretion for personal, cultural, or religious observances that are not otherwise recognized as company holidays.

Veterans Day

To our team members who served in the U.S. Armed Forces, we thank you for your service! To show our appreciation Otak provides a paid day off on Veteran's Day for all Regular Employees who have served in the Armed Forces of the United States (Army, Marine Corps, Navy, Air Force, Space Force, Coast Guard, and National Guard). Employees meeting requirements of service as stated in the Veterans Day Benefit Policy may request and observe Veteran's Day as a paid day off each year.

SEE PEOPLE SERVICES FOR A COPY OF THE FULL PTO AND LEAVE POLICIES, AND/OR IF YOU HAVE QUESTIONS



Volunteer Program

Otak has a long history of supporting our local communities through volunteer opportunities. Today we feel even stronger about the need to be active participants by volunteering our time and effort to improve the communities in which we work and live. Otak encourages employees to draw on their experiences, talents, and passions to find volunteer opportunities in their communities.

While not fully inclusive of opportunities available, Otak has identified five examples of focus that are approved volunteer categories: Education, Environmental Stewardship, Veterans and Military Families, Disaster Services, and Youth Programs.

If you have a specific non-profit organization in mind and you are not sure if it would qualify, please ask People Services. Please note that any time spent volunteering for professional organizations such as AIA, ASLA, APWA, and ASCE, while extremely important, do not count toward the volunteerism program. Additionally, volunteering with your child's sports league is also exempt from this policy.

Accruing PTO Through Volunteering

To encourage and reward you for taking part, Otak will offer paid time off (PTO) to those who volunteer their time towards organizations that focus on giving back to the community through volunteerism. You will receive one PTO day of 8 hours for every 16 hours of volunteer time, not to exceed 3 PTO days annually. Volunteer hours completed in one calendar year can be carried over to the next year until 16 hours of activity has been accumulated.

Otak will make an effort to coordinate group volunteer activities throughout the year. These volunteer efforts may include, but are not limited to, organizations such as local watershed councils, Friends of Trees, American Rivers National Clean Up, regional food banks, United Way, etc. Volunteer events will be communicated throughout as they come up. Additionally, Otak encourages employees to coordinate team events for organizations that inspire them.

To accrue PTO, you will be responsible for submitting the Volunteer forms to Payroll for the time volunteered in 16 hour increments. The form must be complete with your manager's signature. You can access this form on the HR section of Otak Intranet page.



Contacts and Resources

Benefit	Provider / Contact	Contact Info.
People Services	Alyssa Guzman	(503) 415-2324 alyssa.guzman@otak.com
People Services	Craig Meunier	(503) 415-2328 craig.meunier@otak.com
Medical	Regence	(888) 675-6570 www.regence.com
Health Savings Account	Health Equity	(866) 382-3510 healthequity.com
Voluntary Worksite Benefits: Accident, Critical Illness, Hospital Indemnity	Unum	(866) 679-3054 www.unum.com
Dental	Delta Dental of Oregon	(888) 217-2365 www.deltadentalor.com
Vision	VSP	(800) 877-7195 www.vsp.com
Flexible Spending Account Transportation Account	WEX	(866) 451-3399 www.wexinc.com
Life/ AD&D, Voluntary Life/AD&D, Short Term Disability, Long Term Disability, Worksite Benefits	Unum	(866) 679-3054 www.unum.com
EAP	LifeBalance	(800) 854-1446 www.unum.com/lifebalance
Washington State Paid Family Medical Leave (WAPFML)	State of Washington	(833) 717-2273 paidleave@esd.wa.gov https://www.paidleave.wa.gov/workers

For questions about the available plans, escalated claims assistance and general employee benefit guidance, please reach out to People Services.

Alyssa Guzman: alyssa.guzman@otak.com 503.415.2324

Craig Meunier: craig.meunier@otak.com 503.415.2328



Notices, Special Rights and Privacy

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents due to other coverage, you may be able to enroll later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards it) if you request enrollment within 31 days. If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may also be able to enroll later if you request enrollment within 31 days of the event. To request special enrollment or obtain more information about your Special Enrollment Rights, contact People Services.

Privacy Policy

You are entitled to receive an explanation of how your personally identifiable health information will be used and disclosed. For example, a physician or hospital is required to provide you with a Notice of Privacy Practices at your first visit. You will be required to sign an acknowledgment indicating that you received the Notice of Privacy Practices. If you have health insurance coverage, the insurance company or health plan will also provide you with a Notice of Privacy Practices immediately after you are enrolled in the plan. It is important that you read the Notice of Privacy Practices in order to understand your rights and know who to contact if you feel your privacy rights have been violated. Contact People Services for a copy of our health plans' Notice of Privacy Practices.

Women's Health and Cancer Rights Act of 1998 - Enrollment Notice

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.

If you would like more information on WHCRA benefits, call your plan administrator.

For more information regarding your rights after a mastectomy, visit:

<https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resourcecenter/publications/your-rights-after-a-mastectomy.pdf>

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](tel: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-EBSA (3272)

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022.

Contact your State for more information on eligibility.

List begins on the next page

ALABAMA - Medicaid	ALASKA - Medicaid
Website: http://myalhipp.com/ Phone: 1.855.692.5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: Click Here
ARKANSAS - Medicaid	CALIFORNIA - Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA - Medicaid
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://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA- Medicaid	INDIANA - Medicaid
GA HIPP Website: https://medicaid.georgia.gov/healthinsurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-partyliability/childrens-health-insurance-program-reauthorizationact-2009-chipra Phone: 678-564-1162, Press 2	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)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 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 Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	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	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/people-we-serve/children-andfamilies/health-care/health-care-programs/programs-andservices/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programsservices/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPPProgram.aspx Phone: 1-800-692-7462 CHIP Website: Children’s Health Insurance Program (CHIP)(pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

SOUTH CAROLINA – Medicaid	SOUTH DAKOTA – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premiumassistance/famis-select https://coverva.dmas.virginia.gov/learn/premiumassistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-andeligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, 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 on 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)

Medicare Part D

Creditable Coverage Notice

Important Notice from Otak, Inc. Employee Health Plan About Your Prescription Drug Coverage and Medicare

Health Plan: Regence BlueCross BlueShield PPO 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 Otak, Inc. Employee Health Plan 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. Otak, Inc. Employee Health Plan has determined that the prescription drug coverage offered 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 to 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 **Otak, Inc. Employee** Health Plan coverage may or may not be affected.

If you do decide to join a Medicare drug plan and drop your current **Otak, Inc. Employee** Group Health Plan coverage, be aware that you and your dependents may or may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with **Otak, Inc. Employee** 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 November 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 Otak, Inc. Employee Health Plan changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: **September 15, 2025**
Name of Entity/Sender: **Otak, Inc.**
Address: **808 SW 3rd Ave Suite 808, Portland, OR 97204**

Medicare Part D

Non-Creditable Coverage Notice

Important Notice from Otak, Inc. Employee Health Plan About Your Prescription Drug Coverage and Medicare

Health Plan: Regence BlueCross BlueShield HSA 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 Otak, Inc. Employee Health Plan 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. Otak, Inc. Employee Health Plan has determined that the prescription drug coverage offered 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 Otak, Inc. Employee Health 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 the Otak, Inc. Employee Health Plan. 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.

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 to December 7.

However, if you decide to drop your current coverage with **Otak, Inc. Employee Health Plan**, since it is employer sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the **Otak, Inc. Employee Health Plan**.

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

Since coverage under the Otak, Inc. Employee Health Plan is not creditable, 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 November to join.

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 Otak, Inc. Employee Health Plan coverage may or may not be affected.

If you do decide to join a Medicare drug plan and drop your current Otak, Inc. Employee Health Plan coverage, be aware that you and your dependents may or may not be able to get this coverage back

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: **September 15, 2025**
Name of Entity/Sender: **Otak, Inc.**
Address: **808 SW 3rd Ave Suite 808, Portland, OR 97204**

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved OMB No. 1210-0149 (expires 12-31-2026)



PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.²

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

For more information about your coverage offered through your employment, please check your health plan's 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](https://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.

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer Name Otak, Inc.	4. Employer Identification Number (EIN) 93-0788869	
5. Employer address 808 SW 3rd Avenue, Suite 800	6. Employer phone number (503) 287-6825	
7. City Portland	8. State OR	9. ZIP code 97204
10. Who can we contact about employee health coverage at this job? Craig Meunier, Sr. Manager, People Services		
11. Phone number (if different from above) (503) 415-2328	12. Email address Craig.Meunier@otak.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:

Full-time, regular employees of Otak, Inc. or HanmiGlobal USA, Inc. working 30 or more hours a week.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

Spouse, domestic partner, and dependent children under 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 midyear, 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](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

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

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

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage? _____ (mm/dd/yyyy) (Continue)

☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

☐ Yes (Go to question 15))

☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

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

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

16. What change will the employer make for the new plan year? _____

- ☐ Employer won't offer health coverage
- ☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.*
(Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan? \$ _____

b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

Notice Of Privacy Practices

OTAK, INC.
808 SW 3rd AVE STE 800
PORTLAND, OR 97204

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

This Notice of Privacy Practices (the “Notice”) describes the legal obligations of Otak, Inc. Health Plan (the “Plan”) and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as “Protected Health Information.” Generally, PHI is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearing house, a health plan, or your employer on behalf of the group health plan from which it is possible to individually identify you and that relates to:

- Your past, present, or future physical or mental health or condition;
- The provision of health care to you; or
- The past, present, or future payment for the provision of health care to you

If you have any questions about this Notice or about our privacy practices, please see the contact information at the bottom of this notice.

Effective Date

This Notice is effective **September 15, 2025**.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your protected health information;
- Provide you with certain rights with respect to protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- Follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and make the new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make a material change to this Notice, we will provide you with a copy of our revised Notice of Practices. [Notice will be provided on our website.](#)

How We May Use and Disclose Your Protected Health Information

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

Treatment Alternatives or Health-Related Benefits and Services

We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

To Business Associates

We may contract with individuals and entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions

or to provide the services, our Business Associates will receive, create, maintain, transmit, use, and/or disclose protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, subrogation, or pharmacy benefit management, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

Public Health Activities

We may disclose your protected health information for public health activities. These activities generally include the following:

- To prevent or control disease, injury, or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
- To notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstance, we are unable to obtain the victim's agreement;
- About a death that we believe may be the result of criminal conduct; and
- About criminal conduct.

Coroners, Medical Examiners, and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you health care; (2) to protect your health and safety and the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

- The individual identifiers have been removed; or
- When an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

REQUIRED DISCLOSURES

The following is a description of disclosures of your protected health information we are required to make.

Government Audits

We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your protected health information that are for reasons other than payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

OTHER DISCLOSURES

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
- Treating such person as your personal representative could endanger you; and
- In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

Subject only to limited exceptions, we will send all mail to you. This includes mail that relates to your spouse and other family members who are covered under the Health Plan, and includes mail with information on the use of Health Plan benefits by the employee's spouse and information on the denial of any Health Plan benefits to the employee's spouse and other family members. If we agree to your request regarding Confidential Communications below, we will send mail as provided by the request.

Authorizations

Other uses or disclosures of your protected health information not described above will only be made after obtaining your written authorization. For example, subject to specific conditions, we will not use or disclose psychiatric notes about you; we will not use or disclose your protected health information for marketing; and we will not sell your protected health information. You may revoke your authorization at any time, so long as you make the revocation in writing. Any revocation of authorization will only be effective as to future authorizations. It will not affect the authorizations as to any information that was used or disclosed in reliance upon your prior authorization.

YOUR RIGHTS

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

To inspect and copy your protected health information, you must submit your request in writing to the contact information at the bottom of this notice. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We will generally respond to your request within 30 days after it is received, and if we need additional time to process your request we will let you know during the initial 30-day period.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the contact located at the bottom of this notice.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend your information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the contact at the bottom of this notice. In addition, you must provide a reason that supports your request.

We will generally respond to your request within 60 days. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information that you would be permitted to inspect and copy; or
- Is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have a right to an “accounting” of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purpose of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the contact at the bottom of this notice. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes or carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing to the contact at the bottom of this notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply – for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the contact at the bottom of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Be Notified of a Breach

You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to Receive a Paper Copy of This Notice

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this note at our website, <https://www.otak.com/>

To obtain a paper copy of this notice, please see the contact information at the bottom of this notice.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact.

OTAK, INC.
Attn: SHERI MCELRAVY
808 SW 3rd AVE STE 800
PORTLAND, OR 97204

All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.



2026

Employee Benefits Guide

EFFECTIVE JANUARY 1, 2026