DECKER

"DRIVEN TO BE THE BEST"

2026

Benefits Guide

Inside

Welcome

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

How to Enroll

- **Current Employees:** Open enrollment is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries.
- **New Hires:** Once eligible, you must complete your enrollment within 45 days. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverage.

Enroll online through Employee Navigator

Scan QR code or visit
https://employeenavigator.com/benefits/Account/Login
Company Identifier: **Decker Truck Line**

Need Help?

Call the SISCO Call Center: 1-855-447-4726 ext. 6413

- Monday-Thursday: 7 am – 7 pm (Central)
- Friday: 7 am – 5 pm (Central)

Please have all dependent information available when you call, such as full names, birth dates, and social security numbers.

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Examples include:

- Marriage, divorce, legal separation, or death of a spouse
- Birth, adoption, or death of a child
- Change in child's dependent status
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

Medicare Part D Notice:

If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to page **33 - 34** for details.

Contacts

Decker Benefits Team	Online Enrollment Employee Navigator	Call Center Enrollment SISCO
515-576-4141 ext. 2350 or 2340	https://employeenavigator.com/benefits/Account/Login Company Identifier: **Decker Truck Line**	1-855-447-4726 ext. 6413 Monday-Thursday: 7 am – 7 pm (Central) Friday: 7 am – 5 pm (Central)

Coverage	Carrier	Phone Number	Website/Email
Medical	Aplos Health Plans	1-866-420-8575	https://aplos.health
Prescription Drugs	MedOne	(888) 884-6331	www.medone-rx.com
Condition Management	HealthCheck360	(866) 511-0360	www.healthcheck360.com
Flexible Spending Account	WageWorks	1-877-WageWorks	www.wageworks.com/employees
Dental	Delta Dental of Iowa	(800) 544-0718	www.deltadentalia.com/member/
Vision	Avesis	(800) 828-9341	www.avesis.com
Life/AD&D & Disability	Aflac	Contact the Decker Benefits Department (800) 206-8826 Aflac | Login	
Accident, Critical Illness, Hospital Indemnity	Aflac	Aflac | Login	

Eligibility

Employee Eligibility

All full-time employees working 30 or more hours per week will be eligible for benefits. As a new employee, you have 45 days from your initial start date to enroll in benefits.

- **All Coverages:*** These coverages will take effect on the first of the month coinciding with or following 60 days of employment.

* **IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Dependent Eligibility

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Definition of "Eligible Dependents"

Medical, Dental, and Vision Coverage dependents include:

- **Your legally married spouse.** Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, "spouse" shall not mean a common law spouse or domestic partner.
- **Your dependent children under age 26**. This includes natural, step, foster, adopted, or other children under your legal guardianship.
- For additional eligibility details, please refer to the policy contract or summary plan documents.

Other Coverages: See page 18 for definitions of an "eligible dependent" under the Voluntary Life/AD&D Policy. Please note that benefit-eligible employees cannot be enrolled as a "spouse", and dependent children cannot be covered more than once. Please refer to the policy certificate or HR for more information.

Dependent Verification Requirement

Employees who wish to enroll a dependent in coverage are required to provide supporting documents to verify dependent eligibility. **If we do not have supporting documentation on file, your dependent's coverage will not be processed**. If you are unsure if you have the required documents on file, contact Human Resources.

Applicable documents include:

- Marriage certificate (for spouse)
- Birth certificate (for dependents)
- First page of most recent tax return listing covered dependents (for spouse or dependents)

Working Spouse Provision

As of 1/1/2023, if your legal spouse has medical insurance offered through their employer, they are NOT eligible for the Decker Medical Plan. Only spouses enrolled on the medical plan before that date (1/1/2023) can remain on it.

Medical Plan Opt-Out Benefit

If you purchase your medical insurance elsewhere and meet the opt-out benefit requirements, you will receive a **recurring opt-out payment**. If you choose this option, you will no longer have insurance coverage through our employer-sponsored medical plan.

Opt-Out Benefit Requirements:

- 25 years or more of full-time employment with the company.
- Proof of qualifying medical coverage through an alternative source.
- Plan meets ACA "minimum value" requirements.

Employee Navigator

Access your employee benefits from your computer, tablet, or smartphone!

Save Time
Manage your benefits whenever and wherever you are.

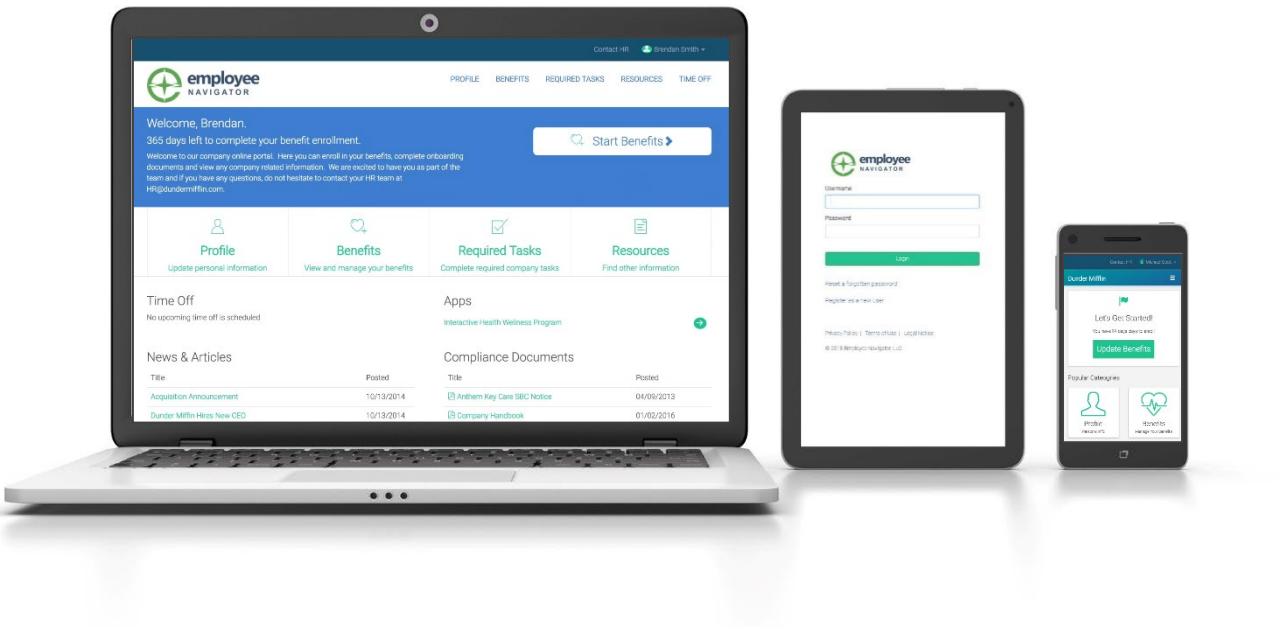
Find Resources
Search providers, carrier customer service numbers, and your company contacts.

Access Benefits
View your benefits, plan documents, and other educational materials.

Download/Print Materials
Download and print generic ID cards, benefit materials, and forms.

Make Decisions
Decide which benefits you want to elect, change, or decline.

Make Changes
Update dependents and beneficiaries if you experience a life-changing event.



Enroll Online through Employee Navigator:

Scan QR code or visit: employeenavigator.com/benefits/Account/Login

Company Identifier: **Decker Truck Line**

Medical

Aplos Health Plans

Locate an in-network provider near you at https://aplos.health or call 1-866-420-8575.

All eligible Decker employees have the opportunity to enroll in Decker's new, enhanced medical plan through Aplos Health Plans. You can call Aplos Health Plans if you need assistance finding a provider, navigating care, verifying eligibility, and/or obtaining pre-certification by calling the number on your ID card.

Medical	Decker Medical Plan	
	Tier 1*	Tier 2*
Annual Deductible Individual Family	 $2,500 $5,000	 $3,000 $6,000
Coinsurance (You Pay)	20%	20%
Annual Out-of-Pocket Maximum Individual Family	 $8,000 $16,000	 $8,000 $16,000
Services	Tier 1*	Tier 2*
Preventive Care	Covered 100%, Deductible Waived	
Exemplar Virtual Care	$0 Copay	
Primary Care Office Visit	$25 Copay	
Specialist Office Visit	$60 Copay	
Urgent Care	$30 Copay	
Emergency Room	$300 Copay + 20% Coinsurance	
Hospitalization	$500 Copay + Deductible then 20%	

*Tier One – Unity Point Health Hospitals and Clinics plus other contracted providers (such as The Iowa Clinic, DMOS, IA Radiology, etc.)

To View all Tier 1 Providers log into your Aplos app and click on "Provider Search"

*Tier Two – All others (STANDARD OUT OF POCKET)

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Prescription Drugs

MedOne administers the prescription drug portion of our medical coverage.

Medical plan participants will automatically be enrolled into the MedOne prescription drug plan. Members will have two ID cards: one for Aplos medical plan benefits to use at the doctor's office, hospital etc., and one for MedOne the prescription drug plan to use at the pharmacy.

Medicare Education

Next Level Planning through our partnership with Cottingham & Butler

As people approach retirement, a common concern is the answer to the question:

"What happens to my health insurance?"

Next Level Planning makes it easy!

- Get advice from licensed insurance agents at no cost or obligation to enroll.
- Explore plans from numerous health insurance companies.
- Learn more about Medicare and be guided through the process.
- Receive 1 on 1 assistance with benefit and financial planning.

Connect with a Medicare consultant.

- (414) 369-6620
- www.nlpm.com

Want NLP to reach out?

Scan QR code or visit:
https://app.smartsheet.com/b/form/9f83ac0937fe480b8d110c7c09a77ed3

Prescription Drugs

MedOne

Available to those enrolled in our medical coverage.

Start here for your drug needs!

Is your drug covered?

Go to www.medone-rx.com/members/drug-lookup and enter **SISCODKRTL**

866-335-9057

$0
Generics

Available at all retail pharmacies except Walgreens and CVS.

$0
Brand Names

Check to see if your brand name medication is available through ControlRx: www.ControlRxInternational.com.

$0
Specialty

*Call NaviCareRx for assistance acquiring specialty medications: 877-371-3351.

Prescription Drugs	In-Network 30 Day Supply	In-Network 90 Day Supply (Retail/Mail)
Rx Deductible (S/F)	$200 / $400	
Generic	$0 at all pharmacies aside from Walgreens/CVS $15 Copay at Walgreens/CVS	$45 Copay
Preferred Brand	$55 Copay	$165 Copay
Non-Preferred Brand	$70 Copay	$210 Copay
Specialty Pharmacy*	Excluded from prescription coverage, however, members may contact a NaviCareRx Patient Coordinator at 1-877-371-3351 for assistance with acquiring specialty medications.	

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail

Manage medications with ease!

MedOne administers the prescription drug portion of our medical coverage. Register or log in to the online member portal to access everything you need concerning your pharmacy benefits. Online you may:

- Check if your medication is covered
- Find in-network pharmacies near you
- Search and compare prices
- Mail order prescriptions to your home

Kannact Diabetes Management

This is a no-cost benefit offered to members in the MedOne Pharmacy Program. Kannact will work with members who have been diagnosed with or told they are at risk for diabetes. If you enroll in the program, your diabetic testing supplies will be at no-cost to you and delivered to your doorstep as you need them. Additionally, you will receive a free glucose meter which will automatically upload blood glucose readings to your private portal for Kannact nurses, doctors, and health coaches to review and help create a personalized management plan.

Enroll in the program by calling MedOne or by enrolling online at www.kannact.com/medone/.

Medical & Prescription Drugs: Cost to You

Medical Weekly Rates	Decker Medical Plan	
Nicotine User Status*	Non-Tobacco	Tobacco*
Employee	$58.00	$74.00
Employee + Spouse	$131.00	$158.00
Employee + Child(ren)	$118.00	$135.00
Family	$146.00	$173.00

* **Tobacco/Nicotine User Designation:** Employees must log into Employee Navigator or call and attest to their tobacco/nicotine status. The employee must attest as to whether or not they have used tobacco/nicotine products within the last 6 months. This designation is for the sole purpose of determining eligibility for the insurance premium discount. Decker reserves the right to discontinue granting discounts at any time with or without advance notice. This discount eligibility does not alter the employment at will relationship between Decker and its employees.

* Employees identified as tobacco users will have an opportunity to complete an alternative standard which will allow them to avoid the surcharge. To avoid the surcharge, you must participate in and complete a company-approved tobacco cessation program, within the first 3 months of the plan year. Successful completion will waive the surcharge for the entire plan year. Please contact Human Resources for more information about how to find and begin an approved cessation program.

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

View the full plan details.

To learn more, you may request a paper copy of any of the plan documents.

Contact the Decker Benefits Team:
515-576-4141 or x2350 or x2340

- Health through Aplos Medical Plan
- Prescription drugs through MedOne Rx
- Dental through Delta Dental
- Vision through Avesis
- Life
- Disability
- Critical Illness, Hospital Indemnity, and Accident through AFLAC

24/7 Urgent/Acute Care Access

Virtual Care

24/7 access to board-certified doctors for treatment of common medical concerns with ongoing communication with your doctor. Accessible virtually through phone, web, and desktop computer.

RECURO HEALTH

Coordinated
If needed, urgent care can seamlessly transition to Recuro's ongoing virtual primary care to improve patient health and preempt future issues.

Convenient
Patients can see a board-certified physician wherever they are, whenever they need it.

Personalized
Patients receive treatment plans based on their unique needs and can ask follow-up questions to their doctors after the visit, free of charge.

Conditions Treated

- Acne / Rashes
- Allergies
- Cold / Flu / Cough
- GI Issues
- Ear Problems
- Fever / Headache
- Insect Bites
- Nausea / Vomiting
- Pink Eye
- Respiratory Issues
- UTI's / Vaginitis
- And More

The average wait time for an urgent care consult is only 11 minutes!

RECURO HEALTH Telehealth

Proactive virtual care solutions that prioritize the patient and prevention.

Go Now

Those in Iowa can still call Exemplar Care if they choose: 24/7 call 515-650-4370 Exemplar Care West Des Moines and they will schedule a virtual call for members. Also can go online: www.exemplar.care

Behavioral Health Care Access

klinic

Quick Appointments, No Waiting Rooms, Convenient Virtual Access, Personalized Treatment Plans, Flexible Scheduling

klinic Behavioral Health

Virtual Care - Expert behavioral health support anytime, anywhere.

Call Now

515-800-4245

- Addiction Treatment (MAT)
- Tele-psychiatry Services
- Counseling and Therapy
- Behavioral Health Medication Management

Visit Aplos.health and download your Aplos App today to get started! GET IT ON Google Play | Download on the App Store

Condition Management

HealthCheck360

The myCare360 program provides education and support for employees, their spouses or children who are managing a chronic condition. The program is a benefit included with your health plan and is provided at no additional cost to you.

You'll receive exclusive access to HealthCheck360's team of clinical experts and support via the easy-to-use mycare360 mobile app.

Conditions covered include:

- Asthma
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes
- Heart Failure
- High Cholesterol
- Hypertension
- Ischemic Heart Disease

myCare360 helps you:

- Stay healthy and manage your condition
- Control your out-of-pocket medical costs
- Learn how recommended care guidelines impact your health
- Have informed conversations with your primary care physician

Getting started

Enrollment in the program is automatic. If you, your spouse, or your child are currently managing a chronic condition, you will receive a welcome letter from HealthCheck360 as well as a call from one of our Care Managers.

Participants who qualify for the program are contacted each quarter by phone, email, or regular mail.

Stay on track with the mycare360 mobile app!

- Company Code: DECKR

Unique ID: Last 4 SSN

Stay on t
mycare3

- Comp
- Uniqu

Health Plan Rates

We want you and your families to enjoy a healthy life and pay attention to your personal health.

By completing the action items listed on your myCare360 account, you will be considered compliant and avoid paying a non-compliant surcharge for health insurance.

The compliance of the program will be monitored January 2026 through October 2026 with the surcharge effective January 1, 2027.

Orthopedic Surgery Alternative

Regenexx

Enhance your body's natural healing with Regenexx!

Regenexx offers a lower-risk, lower-cost, minimally invasive option for many orthopedic surgeries, avoiding up to 70 percent of elective procedures. Using your blood platelets and bone marrow aspirate, Regenexx will process and inject them precisely at the injury site with image guidance. With Regenexx, you can get back to doing what you love without invasive surgery and lengthy recovery.

Regenexx offers a nonsurgical outpatient procedure, done in a day or three treatments over two weeks. Many patients, even those with health concerns like heart issues, can safely return to activity within a week, making it a preferable alternative to surgery.

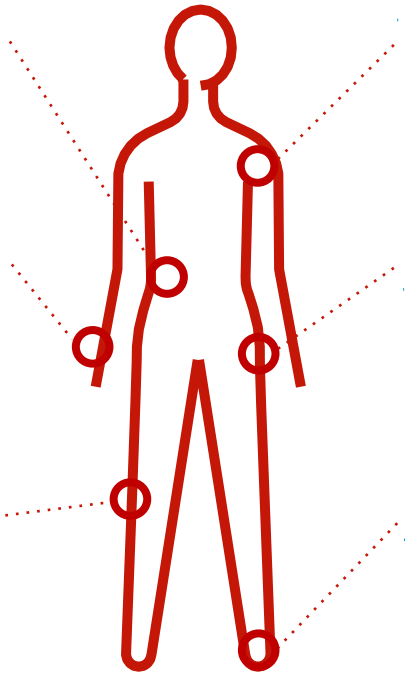
Avoid up to **70%** of elective procedures.

Conditions Treated

Spine
back or neck nerve pain
bulging, collapsed, or herniated disc
ruptured or torn disc
degenerative disc disease
disc extrusion or protrusion

Hand/Wrist/Elbow
arthritis
carpal tunnel
CMC joint arthritis (thumb)
tennis elbow
trigger finger
ulnar nerve entrapment

Knee
arthritis
joint-replacement alternative
meniscus tear
sprain or tear of ACL/PCL or MCL/LCL
tendinopathy



Shoulder
arthritis
joint replacement alternative
labral tear
rotator cuff tears or tendinosis

Hip
arthritis
bursitis labral/labrum tear
joint-replacement alternative
osteonecrosis
tendinopathy

Ankle/Foot
achilles tendinopathy
arthritis
bunions
instability
ligament sprain or tear
plantar fasciitis

Learn More

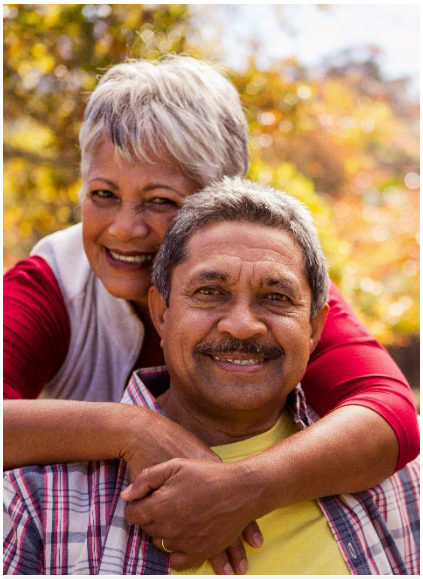
Consult with your health insurance to verify how Regenexx is covered.

For information on the Regenexx benefit and eligibility, contact the education center.

- Register for weekly webinars at www.regenexxbenefits.com/webinar?mailer.
- Contact us at 866-320-2793 or visit www.regenexxbenefits.com/deckertruckline

State & Federal Benefits Assistance

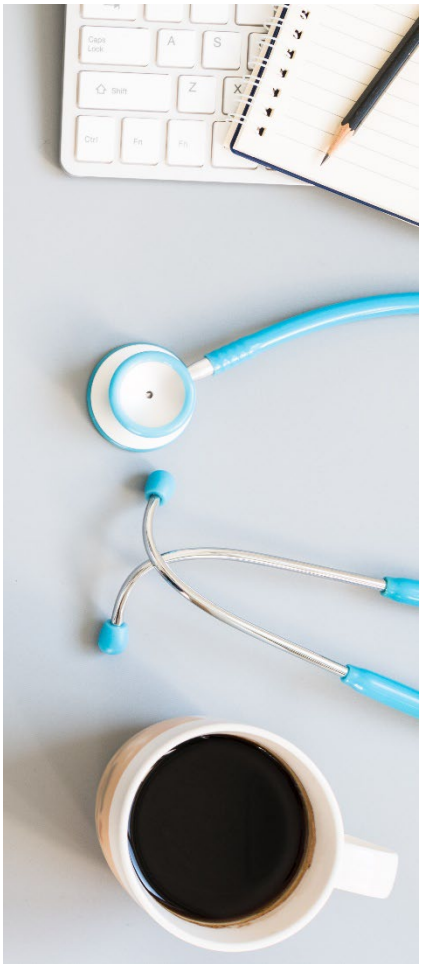
FEDlogic



Schedule a consultation today!

(877) 837-4196

www.fedlogicgroup.com
services@fedlogicgroup.com



We have partnered with FEDlogic to provide state and federal benefits information and advocacy to you and your household members.

The service is free, unlimited, and confidential!

Get help navigating resources that you may be eligible for, such as:

- Medicare
- Medicaid
- Disability
- Social Security Retirement
- Child Benefits
- Widow Benefits
- Veterans Benefits
- Supplemental Security Income (SSI)
- Healthcare.gov (COBRA alternatives)
- End Stage Renal Disease
- ALS (Lou Gehrig's Disease)
- Cancer or Terminal Illness

Here's how it works:

① **Make a phone consultation appointment.**

Call to schedule time with a federal and state benefits expert. Invite your family to join. Calls typically last an hour.

② **Tell us your story, ask questions, and learn.**

Experts will listen to your story and understand your needs, then empower you with unbiased information so you can make the best decisions for your situation.

③ **If qualified, get enrolled.**

Once you feel confident with the information, experts will walk you through the application and approval process.

④ **Enjoy peace of mind.**

Now you know you have access to assistance programs created for situations like this.

Dental

Delta Dental of Iowa

You and your eligible dependents have access to dental coverage through Delta Dental. The Delta Dental Premier Plan offers you a network of preferred providers to make sure you get most affordable dental care.

Dental	In-Network	Out-of-Network
Annual Visit Limits (per person)	Decker offers 3 annual visits. Enrollees also have the added benefit of virtual dentistry which utilizes 1 of your annual visits for payment. More details can be found on the following page.	
Annual Deductible (per person)	$25	$50
Annual Benefit Maximum	$1,000	$1,000
Plan Pays		
Preventive Care	100% Covered; Deductible Waived	
Basic	10%	20%
Major	50%	50%
Orthodontia	Not Covered	

Decker Weekly Cost	
Employee Only	$6.00
Employee + Spouse	$11.00
Employee + Child(ren)	$12.00
Family	$17.00

Locate an in-network provider near you at www.deltadentalia.com/member or call (800) 544-0718.

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

VIRTUAL VISITS

DELTA DENTAL®

Covering you 24/7.

Dental emergencies don't abide by normal business hours. As a Delta Dental of Iowa member you now have 24/7 access to care whenever you need it.

Delta Dental Virtual Visits.

Convenient virtual visits from Delta Dental and TeleDentistry.com are great for members when your dentist is not available and you:

- Have an after-hours dental issue
- Are traveling and need dental assistance
- Face a dental emergency but don't have a regular dentist to call

Virtual Visits come standard with Delta Dental coverage*. In addition to answering questions about unexpected dental issues, virtual dentists can write a prescription and recommend a dentist if you don't already have one.

Start a virtual visit

- Call our 24/7 hotline at **866-302-0443**
- Visit **deltadentalia.com/emergency** to get started

Virtual Visits are easy.

1

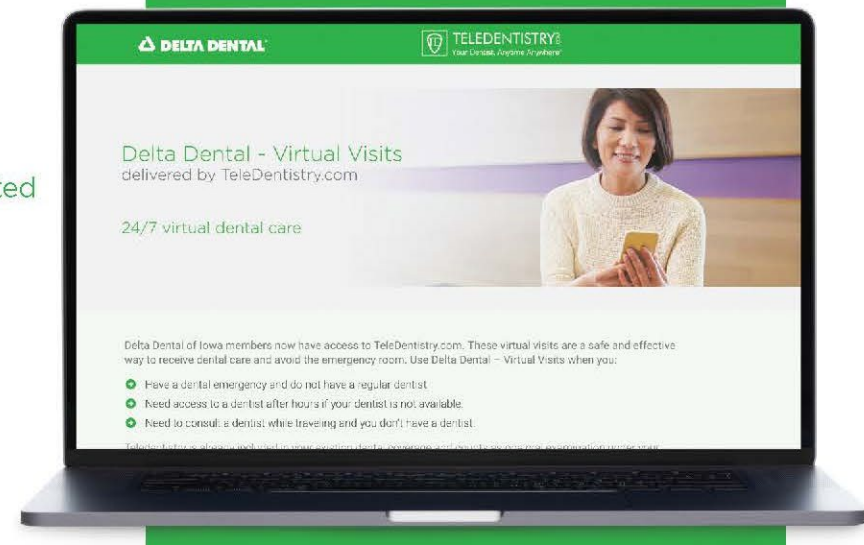
Visit **deltadentalia.com/emergency** to get started and create an account through TeleDentistry.com.

2

Tell us about the problem.
We may ask for a photo upload.

3

Get connected with an online dentist via smartphone, tablet or computer!



TeleDentistry.com services are only available to current Delta Dental of Iowa members.

*A TeleDentistry.com consultation counts as a regular exam under your dental plan. If your plan includes two exams covered at 100% per benefit year, and you receive one teledentistry consultation, you now have one exam remaining.

**E-prescriptions are not available internationally

Vision

Avesis

You will have the option of electing Vision benefits, which are provided through Avesis and include eye exams, lenses, frames and contact lenses.

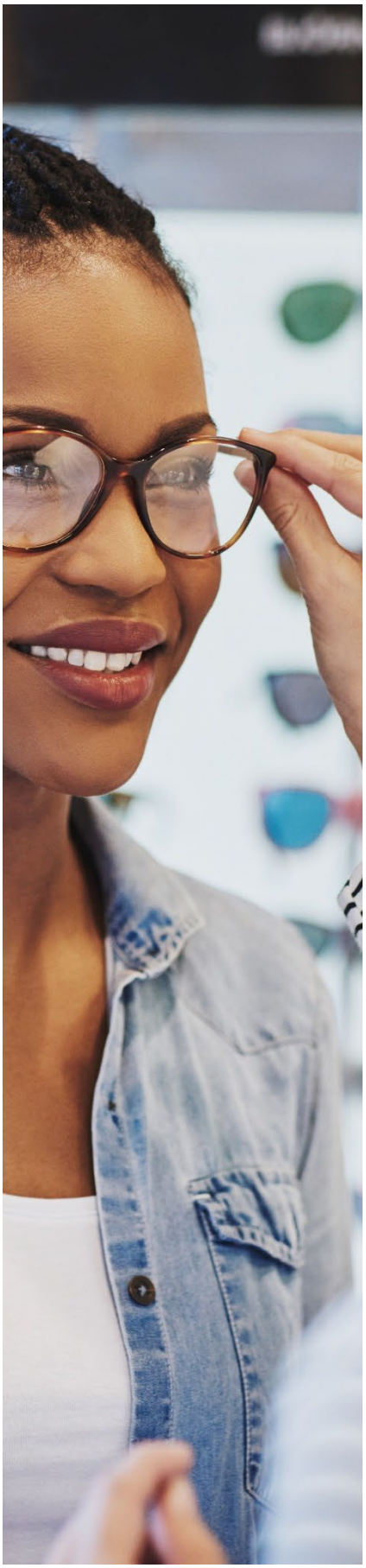
If you visit an Avesis network provider, you simply pay a copayment for exams and there is no claim to file. If you use a non-Avesis provider, you pay the provider for all services and supplies and submit a claim form for reimbursement. You are reimbursed based on a fixed schedule of benefit allowances.

Vision	In-Network
Exam	$10 copay
Lenses	$15 copay
Frames	$15 Copay Up to $150 allowance
Contact Lenses	$130 towards materials and services
Frequencies	
Exams	1 per 12 months
Lenses or Contacts	1 per 12 months
Frames	1 per 24 months

Vision Weekly Cost	
Employee Only	$2.44
Employee + Spouse	$4.90
Employee + Child(ren)	$4.75
Family	$6.43

Locate an in-network provider near you at www.avesis.com
or call (800) 828-9341.

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.



Flexible Spending Account

Health Equity

FSAs can save you money on eligible expenses because you don't have to pay taxes on the amount contributed to the account. However, using an FSA does require careful planning to reap the financial benefits.

Is a Health FSA Right for You?
www.cbmicrosite.com/video/healthfsa

Health FSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Coinsurance
- Copays
- Other health-related expenses

2026 annual contribution limit	$3,400

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.

Dependent Care FSA

Set aside tax-free money to care for children under age 13 or an elderly, dependent parent who is unable to care for themselves. Cover care expenses while you work, such as:

- Preschool
- Summer day camp
- Before and after school programs
- Elder care

2026 annual contribution limit	Married (Filing separately)	$3,750
	Single/Married (Filing jointly)	$7,500

Visit www.irs.gov and search for IRS Publications 502 (Medical and Dental) and 503 (Dependent Care) to learn more about eligible expenses.

Life/AD&D

Aflac

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

Basic Life/AD&D	
Benefit Amount	**Employee:** $10,000 **Spouse:** $5,000 **Child(ren):** $2,500 (age 6 months+) $250 (age 14 days to 6 months)
Benefit Cost	Employer Provided!

Voluntary Term Life/AD&D	
Benefit Amount	**Employee:** Up to the lesser of 5 times annual earnings rounded to the next higher $1,000, or $500,000 **Spouse:** Up to $250,000^ **Child(ren):** Up to $10,000^
Guaranteed Issue Amount[1]	**Employee:** $150,000 **Spouse:** $25,000 **Child(ren):** $10,000
Benefit Cost	To view your personalized rates, log in to Employee Navigator or refer to your benefit highlight sheet or intranet for details.

Benefits may be reduced for employees over age 65 per ADEA.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at time of the effective date. Please refer to the policy certificate or HR for more details. **Definition of "Eligible Dependents"**
It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies.

- **Spouse:** Eligibility may terminate at Spouse age 70.
- **Child:** Eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs. Benefits may be limited for children under age 6 months.

Please refer to the policy certificate or HR for more information.

Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

^ Dependent elections require employee enrollment and may be limited by employee volume.

[Include option A or B if benefit has Guaranteed Issue (GI) row in table]

[A: If no approved open enrollment (also works for new hires)]

A If you enroll when first eligible, you may receive up to the listed amount without having to answer medical questions.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Short-Term Disability

Aflac

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

Short-Term Disability	
Benefit Amount	Replaces 60% of pre-disability income, up to $1,000 per week
Benefit Begins	Injury or illness: after 14 days
Benefit Duration	Up to 11 weeks
Pre-Existing Condition Limitations	3-month look back period 12-month exclusion period

Short-term disability excludes work-related injury or illness.
All newly hired employees are auto enrolled unless you opt out.

Short-Term Disability Cost

To view your personalized rates, log in to Employee Navigator or refer to your benefit highlight sheet or intranet for details.

Pre-Existing Condition Limitations:
If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Statutory Benefits Offset:
Your short-term disability benefit will be reduced by benefits from State Disability/Paid Family & Medical Leave for which you may be eligible.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Long-Term Disability

Aflac

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

Long-Term Disability	
Benefit Amount	Replaces 60% of pre-disability income, up to $5,000 per month
Benefit Begins	After a short-term disability benefits end or, or 90 days
Benefit Duration	Up to Social Security normal retirement age (SSNRA)
Pre-Existing Condition Limitations	3-month look back period 12-month exclusion period

Long-Term Disability Cost

To view your personalized rates, log in to Employee Navigator or refer to your benefit highlight sheet or intranet for details.

Pre-Existing Condition Limitations:
If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Hospital Indemnity Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov or call 1-800-318-2596 (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Supplemental Health

Aflac

The following benefits may protect your financial security in the event of an unexpected medical expense. You can use the payments however you like including out-of-pocket costs related to your care or even daily living expenses.

Accident

Help cover the cost of expenses if you are injured in a non-work-related, covered accident.

Critical Illness

Helps cover the cost of expenses if you are diagnosed with a covered condition.

Hospital Indemnity

Help cover the cost of hospital stays—including pregnancy and childbirth.

Get paid for taking care of your health!

If you are enrolled in coverage, you can receive a **$50 wellness benefit payment** each year when you have a qualifying screening or test.

Supplemental Health Cost

To view your personalized rates, log in to Employee Navigator or refer to your benefit highlight sheet or intranet for details.

Actively-at-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-at-Work/eligible status.

Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at time of enrollment. Please refer to the policy certificate or HR for more details.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Employee Assistance Program

Telus

Available to all employees.

Life. Just when you think you've got it figured out, along comes a challenge. This safe and confidential program is here for you and can help you and your family find solutions and peace of mind.

Confidential Support

- Alcohol or substance abuse
- Childcare
- Eldercare
- Financial problems
- Gambling addiction
- Grief and loss
- Job pressures
- Mental health
- Legal concerns
- Relationships

Connect with a counselor.

1-844-246-7674

https://one.telushealth.com

username: **deckerus** | password: **eap**

If you need additional support, the EAP team will try to refer you to resources that are affordable or covered by your medical insurance.

401(k) Savings Plan

Principal

This page features overview answers for most of the common questions about the Decker Truck Line, Inc. 401(k) Savings Plan. For more information about your plan, refer to the Summary Plan Description available from your employer.

When can I participate in the plan? Once you become eligible (Age 21 and 60 days of service), we'll get everything started for you. Unless you make your own selections, 5% of your pretax pay will go into your retirement account each pay period and your contributions will be invested 100% in the Target My Retirement Program.

How can you learn more and make changes? While your enrollment is automatic, you have 30 days before being enrolled to: Change your contribution rate, direct contributions to other investment options available through your plan or decline participation in the plan.

How much can I contribute to the plan? You may contribute from 1% to 100% of your salary up to $24,500, the maximum the IRS allows in 2026. Review the plan's Summary Plan Description to learn more about how your eligible salary is determined. If you are age 50 or over by the end of the calendar year, you may qualify to make additional "catch-up" contributions of up to $8,000 in 2026. If you are age 60, 61, 62 or 63 by the end of the calendar year, you may qualify to make additional "catch-up" contributions of up to $11,250 in 2026.

Does Decker Truck Line make any contributions? Starting 1/1/26 employer matching contributions are suspended indefinitely.

What if I am automatically enrolled and I do not want to contribute to the plan? If you want to stop contributions to the plan, you can register for online account access at https://login.principal.com/login . Once you are in your account you will need to change your contribution percentage to 0% or contact the Retirement Service Center at 1-800-547-7754.

How can I select a beneficiary for my account? It is important for you to designate a beneficiary for your account by completing the Beneficiary Form during your new hire orientation AND online after you gain account access.

Can I get help making my savings decisions? You can go online and use the Retirement Quick View Calculator to help determine how much you need to save for retirement. After answering a few questions, the calculator shows how much you need to save and how long your current savings will last in retirement. Enter different numbers to see how increasing your savings rate will affect your account balance at retirement or call **1-800-547-7754** for a free 15-minute retirement consultation with a retirement service representative. Your plan offers the Principal Retirement Investment Advice program as a feature to help with your investment decisions. This program has been chosen by your employer and is available to you at no additional cost. The Retirement Investment Advice program allows you to receive a personalized investment recommendation based on personal information that you and your employer provide. Investment recommendations are delivered through Morningstar Investment Management, LLC. You must decide whether to implement the investment recommendation. The Retirement Investment Advice program does not invest or manage your plan account. In addition, the program can help you determine how much you need to save for retirement. To access the Retirement Investment Advice program online, sign on to your account at https://login.principal.com/login .

When do I become vested in my account? Vesting refers to your "ownership" of a benefit from your plan. You are always 100% vested in the money you contribute to the plan and the earnings on that money. You will be vested in your employer's contributions according to the following schedule based on years of service: Less than 1 year 0% 1 year 0% 2 years 20% 3 years 40% 4 years 60% 5 years 80% 6 years 100%

When can I receive money from my account? At retirement; at termination of employment, regardless of age; or Death or disability. You may take a hardship withdrawal in certain cases of financial need as established by IRS regulations. If you receive a hardship withdrawal, your contributions to the plan will be suspended for six months.

Access and make changes to your account two easy ways:
Computer: at https://login.principal.com/login - To get started, select Create an account at the bottom of the page to register for online access, or if you have other Principal accounts that you access online, sign on using the same username and password you use for those accounts. Or go to Principal.com for help.

Call us: 1-800-547-7754 - To access your account by phone, you'll need your Social Security number (SSN). Representatives are also available to answer questions or help you make changes to your account Monday through Friday from 7:00 a.m. to 7:00 p.m. Central Time.

Discount Program

PerkSpot through our partnership with Cottingham & Butler

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

Discount Program			
Shop for a Variety of Coupons & Deals from these Categories:	Apparel Auto Buying Automotive Beauty & Fragrance Books, Movies, & Music Business Perks Cell Phones Education Electronics Financial Wellness Flowers & Gifts Food Health & Wellness Hobbies & Creative Arts	Home & Garden Home Services Insurance & Protection Services Jewelry & Watches Movie Tickets Office & Business Pets Real Estate & Moving Services Sports & Outdoors Tickets & Entertainment Toys, Kids & Babies Travel	
Popular Discounted Brands*	Avis Canon Casper Columbia	Dell Enterprise Holiday Inn	Home Chef HP Ray-Ban
Benefit Cost	Included in our partnership with Cottingham & Butler – no cost to you!		

* All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at https://cottinghambutler.perkspot.com.

Create your account and start saving today.

Visit: https://cottinghambutler.perkspot.com

Who is PerkSpot?

- Online savings resource for employees
- Headquartered in Chicago, IL – Founded in 2006
- 750+ clients nationwide, 15 million members
- 30,000+ discount offers

Website Features

- Recommended for You: chosen based on your top interests
- Featured Offers: hand-selected to help you stretch your dollars
- Today's Perk Alters: today's best limited-time sales
- Popular Savings: trending offers
- Categories: shop by category
- Local Discounts: shop by location

Healthcare Tips

Get the Most Out of Your Care

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-Network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-Network Provider**—A provider who is not contracted with your health insurance company.

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your insurance company, you will be billed differently depending on the type of provider you use for your care.

Provider The patient receives treatment. The doctor then sends the bill to the insurance company.	>	**In-Network Discount** Appropriate discount for using an in-network provider is applied.	>	**Bill** The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.
				v
Patient Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.	<	**Insurance Company Payments, Explanation of Benefits (EOB)** Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.		

Take advantage of preventive care

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

Know Where to Go for Care

Keeping your health care costs in check could be as simple as making the right choice when you need medical care. When you have an illness or suffer an injury, you understandably want to feel better fast, but making the wrong choice about where to receive care can cost you.

The average outpatient emergency room (ER) visit costs $1,917, according to the Health Care Cost Institute. This means that if you head to the ER when you don't really need emergency care, your wallet is going to feel the pain.

Where Should I Go?

Sometimes, it can be difficult to know where to draw the line when it comes to choosing if you should go to the ER, urgent care, or your primary doctor. Here are a few guidelines to help you know where to go next time you're sick or injured.

Emergency Room ($$$$)

A visit to the ER is the most expensive type of outpatient care and should only occur if there is a true emergency, or a life-threatening illness or injury. Examples of conditions that should be addressed in the ER include, but aren't limited to:

- Chest pain
- Shortness of breath
- Uncontrollable bleeding
- Poisoning

Where Should I Go for Care?
www.cbmicrosite.com/video/knowwheretogo

Urgent Care ($$$)

Urgent care centers handle non-emergency conditions that require immediate attention—those for which delaying treatment could cause serious problems or discomfort. Urgent care visits are less expensive than ER visits but are typically more expensive than a visit to your primary care doctor. These conditions can usually be treated in urgent care centers:

- Sprains
- Ear infections
- High fevers

Doctor's Office ($$)

For most non-emergency illnesses or injuries, the best choice for medical care may be a visit to your primary care physician. Your regular doctor knows you best, has your medical history, and has the expertise to diagnose and treat most conditions. In addition, going to the doctor's office is usually the most cost-effective option.

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

Decker Group Health Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

If an Employee or his/her dependents are NOT currently enrolled in Medicaid or CHIP, and they think they (or any of their dependents) might be eligible for either of these programs, they can contact the State Medicaid or CHIP office or dial **1-877-KIDS NOW** or visit **www.insurekidsnow.gov** to find out how to apply. If they qualify, ask if the state has a program that might help pay the premiums for an employer-sponsored plan.

If an Employee or his/her dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under their employer plan, the employer must allow the Employee to enroll in the employer plan if they are not already enrolled. This is called a "special enrollment" opportunity, and **the Employee must request coverage within 60 days of being determined eligible for premium assistance.** If the Employee has questions about enrolling in the employer's plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2025. V 0.6.0. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

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

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

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

CALIFORNIA – Medicaid
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+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+ Website: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

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

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

INDIANA – Medicaid
Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid/
http://www.in.gov/fssa/dfr/
Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

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

Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

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

MAINE – Medicaid
Enrollment Website:
https://www.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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

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

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

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

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

NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program:
1-800-852-3345, ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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

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

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

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

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

PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

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

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

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

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website:
https://medicaid.utah.gov/expansion/
Utah Medicaid Buyout Program Website:
https://medicaid.utah.gov/buyout-program/
CHIP Website: https://chip.utah.gov/

VERMONT – Medicaid
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select
https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

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

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

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

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

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

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

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

Patient Protection Notice

If the Decker Group Health Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). 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.
- 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. ❖

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.96% of household income for the plan year beginning in 2026, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

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

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

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

* 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% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)
If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

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

HIPAA Notice of Privacy Practices
The Decker Group Medical Plan (the "Plan"), which may include other health and welfare benefit offerings, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures Decker has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:
As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:
When required to do so by any federal, state or local law.

4. Health Oversight Activities:
To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:
As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:
To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:
If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:
For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation:
As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach
Decker is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each

individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Decker, 4000 5th Ave S, Fort Dodge, IA 50501, (515) 576-4141.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Decker, 4000 5th Ave S, Fort Dodge, IA 50501, (515) 576-4141. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at Decker, 4000 5th Ave S, Fort Dodge, IA 50501, (515) 576-4141. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Decker, 4000 5th Ave S, Fort Dodge, IA 50501, (515) 576-4141. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Decker, 4000 5th Ave S, Fort Dodge, IA 50501, (515) 576-4141. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Decker, 4000 5th Ave S, Fort Dodge, IA 50501, (515) 576-4141 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at Decker, 4000 5th Ave S, Fort Dodge, IA 50501, (515) 576-4141. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from Decker Group Health Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Decker 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. Decker has determined that the prescription drug coverage offered by the Decker Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

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

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

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

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

For More Information about this Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Decker 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: January 29, 2026
Name of Entity/Sender: Decker
Contact--Position/Office: Human Resources
Address: 4000 5th Ave S, Fort Dodge, IA 50501
Phone Number: (515) 576-4141 ❖

HIPAA NOTICE OF PRIVACY PRACTICES
ADDENDUM

Effective February 16, 2026

Our Notice of Privacy Practices describes how we may use or disclose your Protected Health Information. The following is an update required by the U.S. Department of Health and Human Services (HHS) about the confidentiality of medical records pertaining to substance abuse disorder treatment.

Substance Use Disorder (SUD) Treatment Information. Some of your health information may be part of a SUD patient record and subject to additional protections under federal law (42 CFR Part 2) governing confidentiality of SUD patient records.

If we receive or maintain any information about you from a SUD treatment program that is covered by 42 CFR Part 2 (a "Part 2 Program") through a general consent you provide to the Part 2 Program to use and disclose the SUD patient record for purposes of treatment, payment or health care operations, we may use and disclose your SUD patient record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your SUD patient record through specific consent you provide to us or another third party, we will use and disclose your SUD patient record only as expressly permitted by you in your consent as provided to us. In no event will we use or disclose your SUD patient record, or testimony that describes the information contained in your SUD patient record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.