



2026-2027 EMPLOYEE BENEFITS GUIDE

JULY 1, 2026 - JUNE 30, 2027



TheZenith®
A FAIRFAX Company



WELCOME

Our success is driven by the talent and dedication of our employees. Every individual contributes to our achievements, and our goal is to offer a comprehensive, competitive benefits program that helps attract and retain exceptional people.

We strive to offer benefits that are easy to understand, easy to access, and affordable for you and your loved ones. Our longstanding commitment to wellbeing is reflected in our focus on four key dimensions: Physical, Emotional, Financial, and Community. These programs offer tools and support to help you live healthier, more secure, and more fulfilling lives.

Our medical plan is designed to simplify your healthcare experience, giving you confidence as you balance work and life. We remain committed to supporting your overall wellbeing by providing resources that help you maintain optimal health and focus on what matters most.

Your benefits are an important part of your total compensation. As shown in our Benefits Ecosystem, you have access to a wide range of programs and resources throughout your career with us.

Use this benefits guide throughout the year to stay informed and make proactive decisions that support the health and wellbeing of you and your family.

NAVIGATION OVERVIEW

The guide functions like a website. By clicking on the top navigation bar and interactive icons found in the footer of all pages, you can jump to specific sections within this guide. Look for links that will take you to more information on a topic.

 **HOME page**

 **PRINT**

 **One page BACK**

 **One page FORWARD**

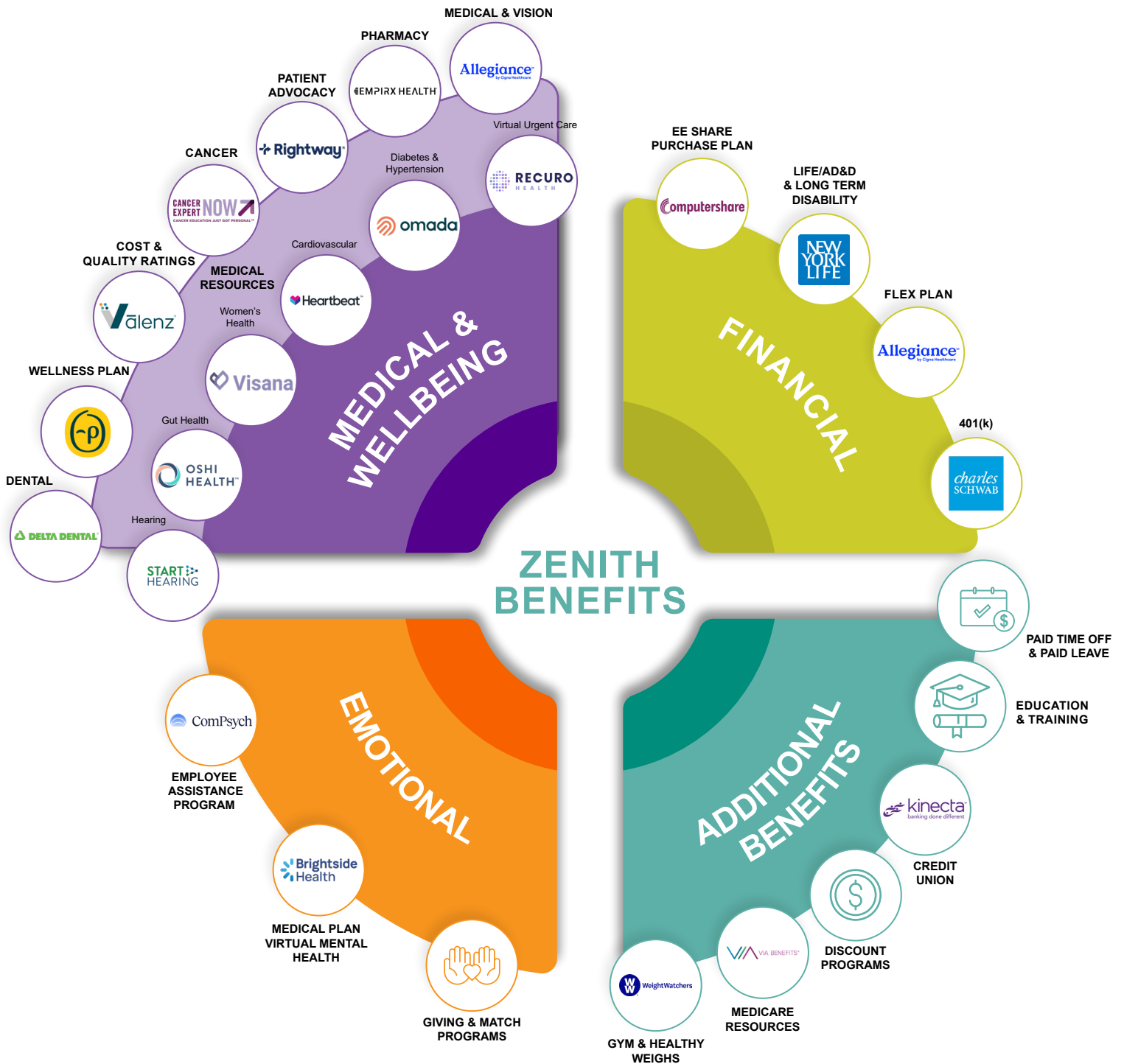
 **View PLAN RATES**

 **Carrier CONTACTS**

 **Glossary of TERMS**

The information contained in this Benefits Overview is only a brief summary of the benefits provided and is for reference/overview purposes only. Additional limitations may apply to the coverages mentioned in this overview. Review each Plan's Summary Plan Description, Evidence of Coverage booklet, Insurance Certificate booklet, as applicable, for a complete explanation of covered services/benefits. If there are any discrepancies in the information provided in this overview, the actual SPD/booklet/plan documents govern all rights and responsibilities.

ZENITH BENEFITS ECOSYSTEM



ELIGIBILITY

WHO IS ELIGIBLE

Employees who regularly work 20 hours or more per week are eligible for the benefits described in this guide.

Dependents:

- Your legal spouse
- Your children up to age 26

CLICK HERE for more information on eligible employees and dependents.



COVERAGE BEGINS AND ENDS

COVERAGE BEGINS

- On the first day of the month following your date of hire, if you enroll timely.
** Employees hired on the first of a month may become effective as of date of hire*

COVERAGE ENDS

- On the last day of the month following your date of termination
- On the last day that you pay contributions to the Plans
- For life insurance your coverage ends on date of termination (conversion and portability options available).
- When you or your eligible dependents no longer meet the eligibility definition (In most cases, dependent coverage ends on the last day of the month in which your dependent child turns 26. Child Life Insurance ends the day before your child's 26th birthday).

Note: If you leave Zenith, you may be eligible to continue Medical, Dental, Vision, and Health Care Flexible Spending Account coverage under COBRA.

MAKING CHANGES TO YOUR BENEFITS

Open Enrollment is the only time of year that you can make changes to your enrollment selections, unless you have a Qualified Life Event, such as:

- Marriage, divorce, or legal separation
- Birth or adoption of a child
- Loss or gain of other coverage by you or a dependent
- Eligibility for Medicare or Medicaid
- Death of an eligible dependent

You have 30 days from the event to make changes or you must wait until the next Annual Open Enrollment period.

CLICK HERE for more information on Qualifying Life Events.





ENROLLING IN BENEFITS

LOGIN INSTRUCTIONS

Your benefit elections can be made by logging into eCentral. You are eligible to enroll in the first 30 days following date of hire, or you experience a Qualifying Life Event, or during Open Enrollment.

When enrolling dependents have **these items** ready.

CLICK HERE

for the description of which Benefit Plans require an enrollment application or waiver.



YOUR COSTS

JULY 1, 2026 - JUNE 30, 2027

The employee contribution amounts shown apply for the Plan Year July 1, 2026 through June 30, 2027. Zenith covers the majority of the cost of medical, dental, and vision coverage. Your monthly contributions are deducted from your paycheck on a pre-tax basis in accordance with IRS regulations, which helps reduce your taxable income.

MEDICAL PPO PLAN

MONTHLY CONTRIBUTIONS	If your annual base salary (as of 1/1/2026) is:		
Enrollment Levels*	Less than \$100,000	\$100,000 - \$175,000	\$175,000 and above
Employee	\$132	\$165	\$186
Employee + Spouse	\$290	\$362	\$410
Employee + Child(ren)	\$237	\$296	\$336
EE + Spouse + Child(ren)	\$395	\$494	\$559

* Vision Plan coverage is offered in conjunction with coverage under the medical plan. There is no contribution for vision coverage.

DENTAL PPO PLAN

MONTHLY CONTRIBUTIONS	
Employee	\$9
Employee + Spouse	\$18
Employee + Child(ren)	\$22
EE + Spouse + Child(ren)	\$32

COBRA MONTHLY PREMIUMS

COBRA provides you and your eligible covered dependents with the ability to temporarily continue your employer-sponsored group health coverage after leaving your job or experiencing a qualifying event, maintaining the same benefits you had as an employee but paying the full premium.

COBRA MONTHLY PREMIUMS

	MEDICAL	DENTAL	VISION
Employee	\$1,118.69	\$44.57	\$9.77
Employee + Spouse	\$2,461.13	\$89.14	\$17.58
Employee + Child(ren)	\$2,013.66	\$106.97	\$18.56
EE + Spouse + Child(ren)	\$3,356.08	\$156.00	\$29.31

MEDICAL & WELLNESS PROGRAM



Allegiance
by Cigna Healthcare

The Zenith Wellness Plan is designed to inspire and support you in maintaining and improving your health. We aim to provide a clear and empowering pathway to wellbeing—one built on prevention, education, early detection, health management, and regular physical activity.

The Wellness Plan encourages you to stay actively engaged in your health throughout the year. By completing certain health-focused activities (“Qualifying Activities”) you can qualify for the Wellness Incentive – a monthly Employee Premium Credit reducing your employee contributions for the Medical Plan, beginning on July 1, 2027 (if hired on or before January 1, 2027). If you have a spouse enrolled in our medical plan, they too can earn a Spouse Premium Credit by completing the Spouse Qualifying Activities.

This program is here to support you, helping you build healthier habits, know your numbers, stay informed, and feel confident in your wellbeing journey. Your health matters, and we’re proud to offer tools that help you thrive both at work and in life.



CLICK HERE for plan details.

No one is precluded from a wellness incentive if meeting or attempting to meet the program requirements is medically inadvisable or unreasonably difficult due to a medical condition. Reasonable alternative standards and waivers are available if applicable.

PERSONIFY HEALTH

New Participant Registrations:

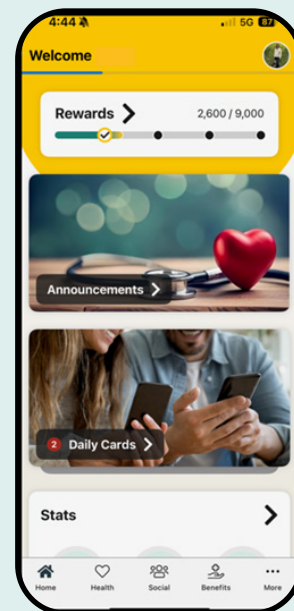
<https://enroll.personifyhealth.com/#!/>

Passphrase: shiny-onion-58

Returning Participants:

<https://login.personifyhealth.com/>

Download Personify Health’s Mobile App and access wellbeing resources anytime, anywhere.



ADDITIONAL PERSONIFY HEALTH RESOURCES

- Track Your Stats
- Create Healthy Habits
- Take Health Journeys
- Check out the Sleep Guide and Nutrition Guide.
- Challenge friends to a walk-off!
- Browse quick, informative videos on fitness, mindfulness and more!



**SCAN HERE TO
DOWNLOAD**





ZENITH WELLNESS PLAN

Qualifying Period: May 1, 2026 – April 30, 2027

Reward Begins: July 1, 2027

The Zenith Wellness Plan is completely voluntary. Participate in the plan, complete all the required qualifying activities, and reduce your monthly contributions for the Medical Plan, beginning July 1, 2027.

EMPLOYEE

\$30/month premium credit
Complete all 5 qualifying activities

ENROLLED SPOUSE

\$20/month premium credit
Complete any 3 of 5 qualifying activities

COMBINED HOUSEHOLD SAVINGS OPPORTUNITY

Up to \$600 in Annual Savings

When **you (\$30/mo)** and your **enrolled spouse (\$20/mo)** both meet the applicable Qualifying Activities, you'll receive a monthly premium credit beginning July 1, 2027.

$\$30 \text{ employee credit} + \$20 \text{ spouse credit} = \$50/\text{month} \times 12 \text{ months} = \$600/\text{year}$
Must be enrolled in the Medical Plan to receive the credit.

QUALIFYING ACTIVITIES BY PARTICIPANT

EMPLOYEE — All 5 Required (If hired on or before May 1, 2026)	SPOUSE — Any 3 of 5 Required (If enrolled anytime between 5/1/2026 – 12/31/2026)
• Health Check Assessment	• Health Check Assessment
• Biometric Screening	• Biometric Screening
• Meet Wellness Measures (blood pressure, glucose, cholesterol, triglycerides, BMI/waist circumference, tobacco-free) or complete Alternative Standards (Health Journeys)	• 3 Preventive Care Screenings
• 3 Preventive Care Screenings	• Complete a Health Journey
• 2 of 4 "Stay Active" Quarters	• Complete 1 "Stay Active" Quarter

EMPLOYEE QUALIFYING ACTIVITIES BY HIRE DATE

Hire Date	Qualifying Activities
On or before 5/1/2026	Complete all 5 of the qualifying activities during the qualifying period 5/1/2026–4/30/2027 to earn the credit.
5/2/2026 – 12/31/2026	Complete the Health Check Assessment, Biometric Screening, and obtain 3 Preventive Care Screenings during the qualifying period 5/1/2026–4/30/2027 to earn the credit.
1/1/2027 – 4/30/2027 *Not Eligible	Not eligible to participate in this qualifying period. Eligible to participate beginning with the next qualifying period (May 1, 2027 – April 30, 2028).

SPOUSE QUALIFYING ACTIVITIES**

Spouses	Complete 3 of 5 of the qualifying activities during the qualifying period 5/1/2026–4/30/2027 to earn the credit.
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****Note:** Spouse eligibility requires continuous enrollment under Zenith's Medical Plan at any point between May 1, 2026, and January 1, 2027.
Questions? Contact HR or visit the benefits intranet.

ALLEGIANCE



Zenith offers a comprehensive medical plan to you and your eligible family members. It is a PPO plan with one of the largest provider networks nationwide, Cigna's Open Access Plus PPO.

Our medical plan is self-funded which means Zenith funds the claims as they are incurred. We've used Allegiance Benefit Plan Management ("Allegiance"), a third party administrator ("TPA") and wholly owned subsidiary of Cigna, to process our claims since 2015.

OUR PERSONALIZED WEBSITE

Access askallegiance.com/zenith for personalized services regarding our health plan. By registering, you will have 24 hour access to your claims and other information. You can:

- Check the status of a claim
- Watch informative videos
- Verify who is covered under your plan
- Request an ID Card
- Download health forms
- Download a digital ID Card
- Review coverage and benefits

ALLEGIANCE CLAIM ADMINISTRATION WITH ACCESS TO CIGNA'S PPO NETWORK

- Allegiance handles the claims and customer service and utilizes Cigna's Open Access Plus PPO Network (OAP)
- No referral is required to see a specialist
- Members traveling outside their home area can still access care through the Cigna PPO network
- Allegiance provides resources like Valenz to compare costs and quality, empowering you to make smarter healthcare decisions



Download on the
App Store



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Google Play

SCAN THE QR CODE TO
DOWNLOAD THE APP

Call Allegiance Member Services
at 855.333.1007



MEDICAL PPO PLAN



Choosing doctors, hospitals, and providers in Cigna's Open Access Plus PPO network gives you access to pre-negotiated rates that can reduce your out-of-pocket costs. Staying in-network not only lowers what you pay at the time of care—it also helps keep overall plan costs down for everyone. Out-of-network providers often charge much more, and those extra costs are usually your responsibility (balance billing). By staying in-network, you get the most value from your medical plan and keep healthcare more affordable. New hires will automatically be enrolled in ZPlusActive.

MEDICAL BENEFITS	ZENITH MEDICAL PLAN LEVEL	ZPlusActive LEVEL
Deductible (Combined Network and Non-Network)	\$1,500 per Individual	\$500 per Individual
Annual Out-of-Pocket Maximums (Includes deductible) Network Only Combined Network and Non-Network	\$3,500 Individual / \$6,500 Family \$6,500 Individual / \$12,000 Family	\$2,000 Individual / \$4,000 Family \$4,000 Individual / \$8,000 Family
Coinsurance (Percentage you pay after deductible)	20% Network 40% Non-Network	10% Network 30% Non-Network
Covered Services: Network		
Preventive Care	No charge	No charge
Primary Care Office Visit	Deductible + coinsurance	\$20 copay
Specialty Care Office Visit	Deductible + coinsurance	\$40 copay
Urgent Care Facility Visit	\$125 copay	\$50 copay
Urgent Care Telemedicine Visit Recuro Health Non-Recuro Health	\$15 copay \$125 copay	\$15 copay \$50 copay
Emergency Room Visit (if not admitted)	\$225 copay	\$100 copay
Outpatient Lab, X-ray and Pathology	Deductible waived + coinsurance	Deductible waived + coinsurance
CT, MRI, MRA and PET Scans	Deductible + coinsurance	Deductible + coinsurance
Hospital Inpatient Stays	Deductible + coinsurance	Deductible + coinsurance
Outpatient Surgery	Deductible + coinsurance	Deductible + coinsurance
Most Covered Services: Non-Network		
	Deductible + coinsurance	Deductible + coinsurance

Note: Balance billed amounts from non-network providers do not count toward the Combined Network and Non-Network Out-of-Pocket Maximums. This is a brief overview only. The [Summary Plan Description \(SPD\)](#) and plan documents will govern.



CLICK HERE to Access &
Request Your Benefit ID Cards



CLICK HERE to Access Providers



CLICK HERE to see
Employee Contributions



PHARMACY BENEFITS



ZENITH MEDICAL PLAN PHARMACY BENEFIT

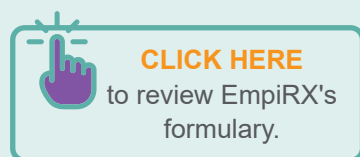
Our pharmacy benefit is administered by EmpiRx Health, and provides access to an extensive national pharmacy network, including all chain pharmacies and most independents.

MEDICAL BENEFITS	ZMP LEVEL	ZPlusActive LEVEL
Retail Prescriptions (30 day) Generic—Preferred Brand—Preferred Brand—Non-Preferred	20% up to \$30 20% up to \$75 20% up to \$150	20% up to \$10 20% up to \$25 20% up to \$50
Mail Order (90 day)	20% coinsurance up to 3x the retail prescription maximums	20% coinsurance up to 3x the retail prescription maximums
Specialty Drug Medications (30 day)	20% coinsurance up to \$250	20% coinsurance up to \$150
Annual Rx Out-of-Pocket Maximums	\$2,000 Individual; \$4,000 Family	\$2,000 Individual; \$4,000 Family

UNDERSTANDING PHARMACY TERMS

Rx Formulary:

The formulary outlines the most commonly prescribed medications from the plan's complete pharmacy benefit coverage list. The formulary identifies which drugs are Preferred and Non-Preferred.



Prior Authorization:

Some medications must be authorized for coverage because they're only approved or effective in treating specific illnesses, they cost more or they may be prescribed for conditions for which safety and effectiveness have not been well-established.

Step Therapy:

Most medical conditions have multiple medication options. Although their clinical effectiveness may be similar, prices can vary widely. With the Step Therapy program, the member gets the treatment they need, usually at a lower cost.

Quantity Limits:

Along with supporting safe and appropriate dosing, quantity limits can keep prescription drug costs lower for the member. Quantity limits are meant to minimize the risk of over-dosing and unwanted drug interactions. Quantity limit rules are based on:

1. Food and Drug Administration (FDA) approved indications
2. Manufacturer's package labeling instructions
3. Well-accepted or published clinical recommendations



SCAN THE QR CODE TO DOWNLOAD THE APP.
myempirxhealth.com

Call EmpiRx Health Member Services at **877.934.2458/** (TDD: 711).





LUNA HEALTH

The plan includes support to help reduce out-of-pocket costs for certain prescription medications. EmpiRx Health, our pharmacy benefit administrator, partners with Luna Health to identify eligible prescriptions and secure available copay assistance through the Patient Saver Plus program.

Copay assistance programs are offered by drug manufacturers for specific medications and can significantly lower what you pay at the pharmacy. When assistance is available for a medication you use, Luna Health will reach out to guide you through the enrollment process and help you access the savings.

The copay assistance program is mandatory. It can meaningfully reduce your expenses and supports our ability to maintain strong and competitive benefits. Participating in the program benefits you by lowering overall prescription costs. If you are contacted by Luna Health, the outreach is legitimate and connected to our pharmacy benefit.

We highly encourage you to make sure that you have your most up to date contact information along with all your covered dependents on file in eCentral.



RIGHTWAY

Your benefits include access to Rightway, a personal health guide service designed to help you make the most of your coverage. Rightway connects you with knowledgeable guides who can help you find in-network providers, understand your benefits, compare costs before receiving care, and resolve billing issues after the fact.

Using Rightway is simple and free to you as a Zenith employee. When you have a healthcare need, reach out to your Rightway guide before scheduling care. They will research your options, confirm network status, and help you avoid unexpected out-of-pocket costs, saving you time and money.

We encourage you to keep Rightway's contact information handy so you can reach them when care needs arise. The service is available to you and your covered dependents. Scan the QR code or call **833.950.4399** to connect with your guide.



RECURO HEALTH

Recuro Health provides a convenient virtual care option available to all covered employees and their dependents. Through Recuro, you can connect with board-certified physicians for non-emergency medical needs — without leaving your home or waiting for an in-person appointment.

Virtual visits through Recuro are available for a flat \$15 copay, giving you predictable, low-cost access to care for common conditions such as colds, infections, rashes, and more. Recuro is especially useful when your primary care provider is unavailable or when an urgent care visit would otherwise be your only option.

To get started, scan the QR code on your benefits guide or visit the Recuro Health portal. Having Recuro set up before you need it means care is only a few clicks away when the time comes.



SCAN THE QR CODE TO
CONNECT WITH YOUR
RIGHTWAY GUIDE



SCAN THE QR CODE
TO VISIT THE RECURO
HEALTH PORTAL

MEDICAL PLAN RESOURCES

MEDICAL & WELLBEING SERVICE PROVIDERS

 CANCER EXPERT NOW CANCER EDUCATION JUST GOT PERSONAL™		Cancer Expert Now offers fast, direct access to leading oncology experts to better understand your, or your loved ones, cancer diagnosis, prognosis, and treatment options. It's an online platform that empowers users by providing personalized oncology education and expert opinions, helping them feel confident in their diagnosis and treatment plans.	
		Valenz Blue Book helps you compare in-network facilities and find fair, lower-cost options for medical care through its website or mobile app, allowing you to see price ranges and high-quality providers so you can make informed healthcare choices and save money.	
		Zenith is committed to supporting employee and family mental health. We offer virtual care through Brightside Health through our medical plan (services are in-network and subject to standard medical plan cost sharing, copays, deductibles, and coinsurance). Brightside provides access to weekly video therapy sessions, online skill-building lessons, psychiatric consultations, unlimited messaging and much more.	
		Our Zenith Medical Plan includes access to Omada Health® (a Cigna PPO provider) weight management, created to help members living with diabetes, and/or hypertension. Omada combines personal one-on-one coaching with practical tools and guidance so you can build healthier habits that last. If you and your eligible adult dependents meet Omada's clinical requirements, Omada is offered to at no cost.	
		Start Hearing (a Cigna PPO provider) is a leading hearing aid company that provides a fully supported path to better hearing through exclusive pricing on the latest technologies. They also give access to a nationwide network of over 3,000 hearing healthcare providers, making professional care easy to reach.	
		Oshi Health is a virtual-first gastrointestinal care clinic providing comprehensive, whole-person care for digestive conditions including IBS, IBD, Crohn's disease, and more.	
		Visana Health is a comprehensive virtual women's health clinic providing whole-person medical care from menstruation through menopause. Visana's team of doctors and nurse practitioners offers longitudinal care for a wide range of women's health conditions – including endometriosis, PCOS, fibroids, contraception, and more.	
		Heartbeat Health is the nation's leading virtual-first cardiology group. A dedicated team of board-certified cardiologists, advanced practice providers, RNs, and care coordinators provides diagnostic interpretation, telecardiology, and care coordination to help address cardiovascular risk before they escalate.	

KNOW YOUR CARE OPTIONS

When you have a relationship with a primary care doctor, you benefit from more personal care. Your primary care doctor will usually be your go-to when you need routine care. Making informed benefit choices helps employees become mindful consumers of care, supporting better use of resources while helping control overall plan costs for everyone. Below is a guide designed to support you in choosing the right care, at the right time, and in the right place.



VIRTUAL VISITS \$-\$\$

When you're sick and need care quick
(e.g., diagnosis, prescriptions, etc.)

- Colds and flu
- Rashes
- Sore throats
- Headaches
- Stomach aches
- Fever
- Allergies
- Acne
- UTIs
- And more



PRIMARY CARE PHYSICIAN \$\$

General health issues (e.g., preventive services, routine checkups, immunizations, etc.)

- General health issues
- Preventive care
- Routine check-ups
- Vaccines and screenings



URGENT CARE \$\$\$

Serious conditions that require immediate medical attention but are not life-threatening
(e.g., minor cuts, sprains, burns, rashes, fever, etc.)

- Fever and flu symptoms
- Minor cuts, sprains, burns, rashes
- Headaches
- Lower back pain
- Joint pain
- Minor respiratory symptoms
- UTIs



EMERGENCY ROOM \$\$\$\$

Serious or life-threatening conditions requiring immediate attention (e.g., major trauma, loss of consciousness, uncontrolled bleeding, etc.)

- Sudden numbness, weakness
- Uncontrolled bleeding
- Seizure or loss of consciousness
- Shortness of breath
- Chest pain
- Head injury/major trauma
- Severe cuts or burns

Not sure where to go? Call Rightway 24/7 at 833.950.4399

Importance of Primary Care

When you establish a relationship with a primary care doctor, they work to get you the right preventive care, manage chronic conditions, and help you improve your overall health and well-being.

Getting an annual physical is the best way to identify potential health issues and help avoid significant health challenges down the road.

VISION PLAN



Vision coverage is only offered in conjunction with coverage under the medical plan and if elected, must cover the same dependents that you enrolled for medical. There is no monthly employee contribution for vision coverage.

There is no provider network for vision benefits. Covered persons can receive covered vision care services listed below from any licensed vision care provider and the applicable Benefit Percentage and Maximum Benefits will apply.

VISION BENEFITS	BENEFIT PERIOD (7/1/25 – 6/30/26)
Vision Exam (Routine vision exam)	100% up to \$135 One per Benefit Period
Spectacle Lenses*	100% up to \$175 Once per Benefit Period
Frames	100% up to \$175 Once every other Benefit Period
Contact Lenses*	100% up to \$175 (instead of spectacle lenses)
Contact Lenses Fitting	100% up to \$80 Once per Benefit Period

**For each Benefit Period the Covered Person is eligible for either Spectacle Lenses or Contact Lenses, but not both.*

CLICK HERE

to request
reimbursement.



CLICK HERE for information on the Allegiance App.

855.333.1007

askallegiance.com/zenith



DENTAL PLAN



Our Delta Dental PPO plan is designed to make dental care simple, flexible, and affordable. With one of the largest dental networks nationwide, you have the freedom to choose your dentist and the confidence that quality care is within reach.

The PPO plan allows you to see any licensed dentist, but you'll receive the highest level of benefits and pay less out of pocket when you use Delta Dental PPO providers. Preventive care, such as cleanings and exams, is typically covered at no cost when you visit an in-network dentist. For basic and major services, the plan shares the cost with you through a deductible and coinsurance.

NETWORK			NON-NETWORK
DENTAL BENEFITS Per Plan Year	DELTA DENTAL PPO DENTISTS**	DELTA DENTAL PREMIER DENTISTS**	NON-DELTA DENTAL DENTISTS**
Deductible (Combined Network and Non-Network)	\$50 per individual \$150 per family	\$50 per individual \$150 per family	\$75 per individual \$225 per family
Annual Maximum (Includes Diagnostic & Preventive Services)	\$2,000 Individual		
Covered Services*			
Diagnostic & Preventive Services Exams, cleanings, x-rays and sealants	100%; deductible waived	100%; deductible waived	80%
Basic Services Fillings and posterior composites	90%	80%	70%
Endodontics (root canals) Covered under Basic Services	90%	80%	70%
Periodontics (gum treatment) Covered under Major Services	90%	80%	70%
Oral Surgery Covered under Basic Services	90%	80%	70%
Major Services Crowns, inlays, onlays and cast restorations	50%	50%	50%
Prosthodontics Bridges, dentures and implants	50%	50%	50%
Orthodontic Benefits			
Adults and Dependent Children	50%; deductible waived	50%; deductible waived	50%; deductible waived
Orthodontic Lifetime Maximums	\$2,000		

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental contract allowances and not necessarily each dentist's actual fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists.



CLICK HERE to Access &
Request Your Benefit ID Cards



CLICK HERE to Access Providers



CLICK HERE to see
Employee Contributions



Scan the QR Code for information
on Delta Dental Benefits, resources
and value-added features.

888.335.8227
deltadentalins.com



FLEXIBLE SPENDING ACCOUNT



Zenith offers eligible employees the opportunity to open a Health and/or Dependent Care Flexible Spending Account(s) (FSAs) administered by Allegiance. An FSA is a tax-free account, in your name, that pays or reimburses you for qualified healthcare or dependent daycare expenses. Your contributions are made pre-tax through payroll deductions.

Open Enrollment determines your benefits for the upcoming plan year, FSAs follow the calendar year—from January 1 through December 31.

HEALTHCARE FSA

The FSA helps you manage out-of-pocket health costs by covering a wide range of eligible expenses, including copays, deductibles, prescription medications, dental and vision care, as well as approved over the counter products.

DEPENDENT CARE FSA (DCFSA)

A Dependent Care FSA allows you to use pre-tax dollars towards qualified dependent daycare expenses. Care must be provided by a qualified dependent daycare service, babysitter, daycare center, or before or after school program. Eligible dependents include children (under the age of 13 who live with you). Care for an eligible disabled spouse, or disabled child over the age of 12 who lives with you, may also be eligible for reimbursement. Dependent Care FSA distributions are limited to the amount you have in your account and cannot be reimbursed until they are actually incurred.

If you have not spent all the amounts in your Healthcare FSA by the end of the plan year, you may roll over up to \$680 (CY 2026) of unused Healthcare FSA funds into the next plan year. Any amount above that is forfeited. Please note that the Dependent Care FSA does not have a roll over. You must spend down the funds by December 31, 2026 and submit receipts for reimbursement within 90 days after the end of the plan year.

HEALTH FSA (CY 2026):
The maximum annual contribution is \$3,400.

DEPENDENT CARE FSA:
The maximum annual limit an employee may contribute is \$7,500 per household.

To utilize tax-free funds for your Health FSA or Dependent Care FSA, you decide how much you contribute to your FSA for the plan year, and contributions are made each pay period. Accessing and using your funds in your FSA is fast and easy with Allegiance through a variety of convenient payment and reimbursement options.



CLICK HERE for a complete list of eligible FSA expenses.

Open Enrollment for Zenith's Flexible Benefits Account Plan takes place in early December for the following plan year.



1: ESTIMATE

Estimate how much to deduct for each FSA.

Your election cannot be changed until January (unless there is a qualifying life event).



2: PAY

When you go to your doctor or pharmacy. You have the choice between a flex debit card or joint processing (not both) to pay for qualified expenses, or pay and submit claims manually. (DCFSA expenses need to be submitted for reimbursement).



3: USE IT OR LOSE IT

Estimate FSA contributions carefully. Any Health FSA funds over \$680 and any remaining Dependent Care funds will BE forfeited (you LOSE IT).



401(k) - RETIREMENT SAVINGS PLAN

The Zenith 401(k) Plan is designed to help you build long-term financial security for retirement. You can contribute with pretax or post tax dollars, which may lower your taxable income, and you have access to a broad range of investment options that are administered through Charles Schwab. Zenith adds to your savings through a company match, giving you a meaningful boost as you plan for the years ahead. Whether you are just beginning to save or refining your strategy as retirement gets closer, consistent planning can make a significant difference over time.

When am I eligible to participate in the plan?

Eligible employees may enroll in the Plan on the date they are employed by Zenith, and enrollment will take effect as soon as administratively practical. You can enroll in the plan and make changes to your contributions at any time.

How much can I contribute to the plan?

In CY 2026, the standard 401(k) contribution limit is \$24,500 for those under age 50. If you are age 50 or older, you can contribute an additional \$8,000 in catch-up contributions, for a total of \$32,500. For those aged 60-63, an even higher catch-up contribution (enhanced catch-up contribution) of \$11,250 is allowed.

You may contribute 1%-50% of your eligible pay on a pre-tax and/or Roth 401(k) basis, annually subject to IRS limits. For those who earned over \$150,000 in 2026, 2027 catch-up contributions must be made in the form of Roth (after-tax) contributions.

Note: this limit includes amounts deferred into a previous employer's 401(k) plan in the current year. Notify HR of this amount, if applicable.

Are pre-tax and after-tax employee contributions permitted?

Yes, you can contribute on a pre-tax or after-tax basis (Roth 401(k)) up to the IRS limits.

What is the employer's contribution?

Zenith matches 75% of the first 6% of pay that you contribute to the Plan.

What is the vesting schedule?

Your vesting schedule is based on your years of service with Zenith and increases 20% a year for up to 5 years at which time you are 100% vested. You are 100% vested in your contributions as well as your rollover contributions made into the plan.

VESTING SCHEDULE	
At 1 year of vesting service	20%
At 2 years of vesting service	40%
At 3 years of vesting service	60%
At 4 years of vesting service	80%
At 5 years of vesting service	100%

CLICK HERE



to request a
rollover.

EXAMPLE: EMPLOYEE EARNING \$50,000 ANNUALLY AND CONTRIBUTING 6% OF PAY (OR \$3,000).

1: Employee's 401(k) Contribution

(6% of pay)

Employee's
Contributions: \$3,000

+

2: Zenith's Contribution

(6% of pay x 75%)

Zenith's Contributions: \$2,250

=

3: Annual Contribution

\$5,250

Total Contribution:
\$5,250



Scan the QR Code for information.

800.724.7526

workplace.schwab.com



EMPLOYEE SHARE PURCHASE PLAN



At Zenith, we are fortunate to be able to take advantage of a long-term savings vehicle, the Employee Share Purchase Plan, also known as “ESPP”.

The ESPP provides you with an opportunity to purchase shares of stock of Fairfax Financial Holdings Limited (“Fairfax”), Zenith’s parent company, using payroll deductions and matching contributions made by Zenith. Here’s a quick summary of how it works:

- Choose an amount that you wish to have deducted from each of your pay checks. The minimum is \$25.00 and the maximum is 10% of your pre-tax pay.
- Zenith will add to your deduction a matching amount equal to 30% of your contribution and the plan administrator will buy shares of Fairfax stock for your account.
- In addition, if our calendar year Combined Ratio is under 100% for the year, Zenith will contribute an additional amount equal to 20% of your contribution after the end of the year (making the total matching contribution in these years 50%).
- You will be able to sell the shares for cash, but there is a minimum amount of time that must elapse before you can do so. After the last day of February, every year, you can sell all of the shares you bought in the preceding year but not before then.



SCAN TO REGISTER
OR LOG IN

computershare.com

888.887.6018

LIFE AND ACCIDENTAL DEATH
& DISMEMBERMENT (AD&D) INSURANCE

BASIC LIFE AND AD&D

Zenith provides employees with Basic Life and AD&D coverage at no cost to employees. It is important to name and update your beneficiaries in eCentral for your life & AD&D coverage.

BASIC EMPLOYEE LIFE AND AD&D		BENEFIT SCHEDULE
Basic Employee Life Insurance	3x Annual Compensation, rounded to the next higher \$1,000, to a maximum of \$750,000. Basic Life Coverage over \$50,000 is subject to imputed income in accordance with IRS requirements	
	An AD&D benefit is payable in the event of certain losses. The benefit schedule is the same as Basic Employee Life; however, the amount payable is based on the type of loss.	
Basic Employee AD&D Insurance Refer to actual booklet for additional types of loss and the AD&D benefit payable.	Life	The full amount
	Sight of Both Eyes	The full amount
	Hearing and Speech	The full amount
	Quadriplegia	The full amount
	Paraplegia	Three quarters the full amount
	Hemiplegia	One half the full amount
	Coma	The full amount after 12 months

VOLUNTARY LIFE

You have the option of purchasing additional life insurance coverage for yourself, your spouse, or your dependent children. Your costs for voluntary life insurance will vary by age. Guarantee Issue (no medical underwriting) applies if you apply when first eligible.

- Employees can purchase additional life insurance of 1x, 2x, or 3x your annual compensation up to a maximum of \$500,000. The Guarantee Issue (GI) is up to \$200,000.
- Spouse coverage can be purchased in increments of \$10,000, beginning from \$20,000 up to \$100,000. The Guaranteed Issue (GI) amount is \$20,000, and a spouse's benefit is limited to 50% of the employee's voluntary life benefit.
- Child coverage can be purchased at \$10,000 per child. All eligible dependent children are covered with one flat premium.

[CLICK HERE](#) for more information on Basic Life.
[CLICK HERE](#) for more information on AD&D.

[CLICK HERE](#) for more information on Supplemental Life.





LONG TERM DISABILITY INSURANCE

Zenith provides Long Term Disability (LTD) coverage to all eligible employees at no cost. This benefit is designed to protect your income if you are unable to work for an extended period because of a serious illness or injury, giving you a reliable level of financial support when you need it most.

180 days

Benefits begin on the 181st day of a covered disability due to sickness, accident, or hospitalization.

66.67%

How much of your weekly earnings you get when you are on your LTD, up to the maximum monthly benefit.

\$15,000

Maximum monthly benefit amount.

WHAT YOU NEED TO KNOW

Definition of Disability

You are considered disabled if, due to illness or injury, you are unable to perform the material duties of your regular occupation, or are unable to earn 80% or more of your indexed earnings while working in your regular occupation.

Benefit Duration

Benefit payments may continue up to the maximum benefit period outlined in the policy, subject to ongoing claim approval and meeting plan requirements. For disabilities that begin before age 62, benefits may continue to your Social Security Normal Retirement Age (SSNRA). Shorter maximum benefit periods apply if the disability begins at age 62 or later.

Pre-Existing Condition Limitation

A pre-existing condition is an injury or illness for which you received treatment, took prescribed medication, had medical expenses, or would reasonably have seen a doctor within 3 months before your most recent effective date of insurance.

The plan will not pay benefits for a disability related to a pre-existing condition if it begins within your first 12 months of coverage. This limitation does not apply once you have been covered for at least 12 months after your most recent effective date of insurance, or after the effective date of any added or increased benefits.

Income

Taxability of disability benefits depends on how premiums are paid. Please consult your employer or tax advisor for additional information.

CLICK HERE



for more information on
Long Term Disability.

EMPLOYEE ASSISTANCE PROGRAM



UP TO 8 FREE COUNSELING SESSIONS PER INCIDENT, PER PLAN YEAR

Short-term counseling available to all employees and their household family members — at no cost to you.

Our Employee Assistance Program (EAP) is provided through **ComPsych** and is available to **all employees and their household family members**. The EAP is intended for short-term counseling needs with up to 8 sessions per incident per plan year provided at no cost to you. You can access the EAP **24/7 by phone, online or mobile app**.



Call Anytime

800.272.7255 (available 24/7)



Online Portal

GuidanceResources.com



Mobile App

GuidanceNow – iOS & Android

SERVICES AVAILABLE TO YOU

In-Person & Phone Support

- Confidential counseling sessions (in-person or phone)
- Anxiety, depression and stress
- Grief, loss and life adjustments
- Relationship and marital conflicts
- Child, elder and pet care guidance
- Moving and relocation support
- Shelter and government assistance

Online & Digital Support

- Secure video counseling sessions
- Connect to counseling and work-life support services
- Articles, podcasts, videos and slideshows
- Legal guidance: divorce, adoption, wills, estate planning
- Free legal consultation & discounted representation
- Financial resources: retirement, taxes, budgeting, debt

Self-Service & On-Demand

- GuidanceNow mobile app (iOS & Android)
- On-Demand trainings to build skills at your own pace
- Financial tools: mortgage, relocation, insurance calculators
- Wellness assessments and personalized action plans
- Library of self-help resources available 24/7



SCAN TO
REGISTER OR LOG
IN AND DOWNLOAD
THE APP.

guidanceresources.com

App: GuidanceNowSM

Web ID: ZENITH

24/7 Live Assistance:

800.272.7255

TRS: Dial 711



CHARITABLE PROGRAMS

At Zenith, giving back is part of who we are. We believe in supporting causes that uplift communities, promote wellbeing, and create lasting change. Through our charitable programs, employees can make a meaningful impact, whether by donating, volunteering, or nominating organizations close to their hearts. From hunger relief to mental health, education to disaster response, Zenith is proud to stand behind efforts that truly make a difference.

Explore the programs below to see how you can get involved:

ZENITH CHARITABLE PROGRAMS OVERVIEW			
PROGRAM NAME	WHAT IT DOES	HOW YOU CAN PARTICIPATE	ANNUAL HIGHLIGHTS
Be the Difference	Supports recurring donations to selected charities via payroll deduction.	Choose a cause and set up donations through eCentral.	2026 charities: Thrive Scholars, Mental Health America, Meals on Wheels, and more.
Volunteer Grant	Rewards employees who volunteer with a donation to their chosen organization.	Volunteer at least 26 hours/year with a qualified nonprofit.	\$500 donation made to your organization on your behalf.
Matching Gift	Matches employee donations to eligible charities dollar-for-dollar.	Submit a matching gift application via Community Dimensions homepage.	One match per employee per calendar year.
Charity Nomination	Allows employees to nominate charities for quarterly grants.	Nominate a charity that aligns with Zenith's values.	Two charities selected each quarter receive \$500 grants.

CLICK HERE

 for more information on Charitable Programs.



PAID TIME OFF

TYPE OF TIME OFF	LENGTH OF SERVICE (IF APPLICABLE)	ELIGIBILITY/HOURS PER WEEK	MAXIMUM ACCRUAL	NOTES
Vacation	Up to 5 years (1-60 months)	If you work 37.5+ hours: 9.38 hours per month; (15 days/yr)	150 hours (20 days)	* Request must be approved in advance * Non-exempt employees may request vacation time as small as 15 minutes and exempt employees need to only record vacation taken for 2 or more hours per day
	Over 5 years (Over 60 months)	If you work 37.5+ hours: 12.5 hours per month; (20 days/yr)	187.5 hours (25 days)	
	Up to 5 years (1-60 months)	If you work 20-37 hours: 7.04 hours per month; (11.25 days/yr)	112.5 hours (15 days)	
	Over 5 years (Over 60 months)	If you work 20-37 hours: 9.38 hours per month; (15 days/yr)	140.63 hours (18.75 days)	
Floating Holidays		If you work 37.5+ hours: 2 days, (15 hours) each year If you work 20-37 hours: 1 day, (7.5 hours) each year	N/A	* Unused floating hours do not carry over to the next calendar year * If you join the company from July 1st to September 30, you are eligible for 1 floating holiday * If you were hired from October 1st and onward of this year, you are not eligible for a floating holiday on the remaining months of your first year of hire * Must be taken in full day increments * Used to observe important personal, cultural, religious or other state federal holidays and events not observed by Zenith
Personal Days		If you work 37.5+ hours: 2 days, (15 hours) each year If you work 20-37 hours: 1 day, (7.5 hours) each year	Maximum accrual cap of 3 days/calendar year	* Made available in a lump sum at the time of hire and reset at the beginning of each benefit year (January 1 through December 31)
Sick Days		75 hours at time of hire/rehire, which will reset to 75 hours at the beginning of each subsequent benefit year. See Handbook for ordinances requiring a more generous sick time benefit	N/A	Paid sick leave balances at the end of each benefit year do not carry over to the next benefit year unless required by a local ordinance for an employee
Paid Holidays		10 Paid Holidays	N/A	See Employee Handbook for listing of holidays
Bereavement Leave		* up to five (5) days paid time following the death of an immediate relative * up to three (3) days of paid time for other relatives as defined in the Zenith Employee Handbook	N/A	N/A

Please review the [Employee Handbook](#) for additional details on time off benefits.



PAID LEAVE

Whether you're facing a personal challenge, caring for a loved one, or managing a medical situation, Zenith's Leave of Absence options are designed to provide the time and flexibility you need. Each type of leave has specific eligibility rules and pay information—some are unpaid. In certain situations, Zenith offers a generous pay continuation benefit. Depending on your circumstances, you may qualify for the following:

- Full pay during the initial 7-day continuous waiting period
- Up to six weeks at full pay*
- Up to 180 days at 75% partial pay*
- Company-paid benefits continue for up to 12 weeks

**Coordinated with benefits received from other disability plans (e.g. State Disability Insurance, Workers' Compensation). Applicable after 12 months of service.*

PARENTAL PAID LEAVE

At Zenith, we recognize the importance of family and the value of time spent with your newest addition. Eligible employees are provided paid Parental Leave following the birth of an employee's child or the legal adoption of a child, as defined below. Paid Parental Leave gives you paid time off to care for and bond with your new child without sacrificing essential family obligations.

Qualifying Parental Leave Criteria

To be eligible for parental leave you must be a regular employee (temporary employees and interns are not eligible), and must be regularly scheduled to work at least 20 hours per week.

Eligible employees must also meet one of the following qualifying criteria/events:

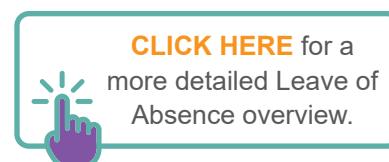
- Have given birth to a new child.
- Be a lawful spouse of someone who has given birth to a new child.
- Have legally adopted a new child (age 17 or younger). Taking leave following an employee's adoption of a stepchild is not covered by this policy.
- Maximum Length of Leave / Use and Timing Requirements

Coordination with Other Policies

Paid parental leave under this policy runs concurrently with any applicable federal FMLA and state leave laws. Leave taken for childbirth, adoption, or pregnancy-related disability counts toward the 12-week FMLA entitlement and any applicable state leave, based on a rolling 12-month period (or as defined by law). All FMLA and state leave requirements apply. Total leave, whether paid or unpaid, will not exceed 12 weeks in the applicable period unless required by law. Refer to the company's Pregnancy Disability Leave and Family Care Medical/Bonding Leave policies for more details.

Requests for Leave

Parental leave that is foreseeable needs to be communicated to the employee's supervisor and the Human Resources Department at least 30 days in advance of the expected date of the leave (and if unforeseeable, as soon as the employee is aware of the need). The employee must complete the necessary forms and provide all documentation as required by the Human Resources Department.



EDUCATION AND TRAINING REIMBURSEMENTS

Zenith believes that successful employees demonstrate a passion for learning and encourages employees to pursue education which will enhance skills used in their current jobs or will prepare them for greater responsibilities and opportunities within the Company.

The four categories of educational expenses supported by Zenith's policy.

1. Job-related education such as workshops, conferences, and seminars
2. College education programs (A.A., B.A., B.S.), - special approval required for M.A., M.S., Ph.D.)
3. Professional insurance designation programs (examples: AEI, IIA, CPCU)
4. Continuing education required to maintain professional certification (attorneys, nurses, etc.)
 - Reimbursement guidelines associated with each type of education
 - Registration and payment procedures

TYPE OF EDUCATION	REIMBURSEMENT PERCENTAGE & TIMING	REQUIRED APPROVALS	PROCESSING
Job-Related Seminars, Workshops, Conferences	100% paid in advance	Manager	Accounts Payable
College/University	75% of tuition, 100% of books up to a combined maximum of \$5,250.00 per calendar year*	Manager, Department Head, and Human Resources BEFORE beginning the school term	Human Resources
Insurance Education	100% paid in advance and subject to course completion	Manager	Accounts Payable
Continuing Education	100% paid in advance	Manager	Accounts Payable

**Subject to Employee Repayment Liability clause.*



CREDIT UNION



Kinecta offers all the products and services of a big bank and top-notch digital banking with more personalized service. They provide special deals, programs and promotions specifically tailored for your needs.

ENJOY THESE PERKS.

When you become a member of Kinecta, you unlock these partner benefits:

- Paycheck deposited up to two days early
- Access to 85,000+ surcharge-free ATMs
- Financial education workshops
- Payday advance loan up to monthly payroll deposits, 2% interest rate, 6–12 months for repayment
- Credit builder credit card guaranteed approved (up to \$1,000)
- No-fee NSF/overdraft (1/month, up to \$25 value)
- New \$250 checking account bonus / Savings Starter
- College Saver Account (a share certificate to help students & their families plan & save for college expenses)
- \$50 match for all employees' children under 1-year old
- Wealth management & insurance services
- No minimum balance requirement, including interest-bearing checking⁹
- Double points on credit card rewards
- Mortgage administration fee waiver (\$950 value)
- Comprehensive financial plan (\$1,500 value)



Scan this code, visit kinecta.org, or call 800.854.9846

VIA BENEFITS - MEDICARE RESOURCE



Via Benefits is a private health insurance marketplace and advisory service that helps individuals—especially retirees and Medicare-eligible participants—find, compare, and enroll in health coverage that fits their needs and budget.

- **Personalized Support:** Licensed benefit advisors help users understand their options and guide them through the enrollment process.
- **Online Tools:** Users can create a profile, input prescription and provider information, and use comparison tools to evaluate plans based on cost, coverage, and network.
- **Medicare Marketplace:** Via Benefits is the largest and oldest private Medicare marketplace, working with national and regional insurance carriers to offer a wide range of plans.
- **No-Cost Service:** Our advisory and enrollment support is provided at no cost to the user.
- **Ongoing Advocacy:** Once enrolled, Via Benefits continues to support users, helping them adjust coverage if their needs or location change.



Scan the QR Code for information.
833.858.1633, discover.viabenefits.com/thezenith



GYM & HEALTHY WEIGHS PROGRAMS



Zenith offers programs that encourage employees to stay active, support their well-being, and manage their health with confidence. These resources are designed to make healthy habits more accessible, whether you prefer a gym setting or a structured weight management program. Each benefit is intended to help you build routines that support long term wellness.

GYM PROGRAM

Zenith recognizes that regular physical activity plays an important role in long term health. For employees working at offices without an onsite gym supported by the company, Zenith reimburses 50% of your gym membership cost up to a maximum of \$250 dollars per year. This applies to eligible full time and part time employees scheduled to work at least 20 hours per week, and reimbursements are subject to applicable tax withholdings.

This program gives you the flexibility to choose a gym that matches your routine and comfort level. Whether you prefer strength training, group classes, or general fitness, the reimbursement helps reduce the financial barrier to staying active. Documentation is required for reimbursement and must be submitted within the timelines outlined in the benefit guide.

HEALTHY WEIGHS PROGRAM

The Healthy Weighs program supports employees who want guidance with long term weight management, healthier eating habits, and sustainable behavior change. Zenith reimburses 50% of the cost of a Weight Watchers program up to a maximum of \$200 dollars per calendar year, available to eligible full time and part time employees working at least 20 hours per week.

Weight Watchers was selected for this program because it offers evidence based coaching, flexible food planning, and support through multiple channels including in person meetings, online tools, and at home options. Employees can file one Extra Pay Request per year for reimbursement, and should retain payment records until they have reached the maximum eligible amount. Requests must be submitted within three months of the end of the year in which the expense was incurred.



Scan this code or visit [weightwatchers.com](https://www.weightwatchers.com)



CLICK HERE

for additional information on
the program.



DISCOUNT PROGRAMS



Entertainment Services EES Tickets

Discounts on theme parks, movies, concerts, sporting events, hotel stays, and more through the EES Tickets Platform.

[CLICK HERE for more information](#)



Car Rental Discount National Car Rental & Enterprise

Discounted rates for personal leisure travel through our national rental car partners.

[CLICK HERE for more information](#)



Airport Parking The Parking Spot

Corporate discount on airport parking – all Zenith employees are eligible to join and start saving immediately.

[CLICK HERE for more information](#)



Pet Health Insurance ASPCA Pet Health Insurance

Up to 10% off premiums for dogs and cats with fully customizable coverage – you choose the limits and deductible.

[CLICK HERE for more information](#)



Mobile Discount Verizon Wireless

Up to 19% off monthly wireless bills on eligible plans, including Monthly Account Access Fees.

[CLICK HERE for more information](#)



Computers & Laptops CDW

Discounts on tablets, notebooks, and desktops through our technology partner CDW.

[CLICK HERE for more information](#)

APPENDIX



ELIGIBLE EMPLOYEE

You are eligible for coverage if you are a regular full-time employee or a regular part-time employee of Zenith regularly scheduled to work 20 hours or more per week.

Participant means an Eligible Employee who is covered under a Benefit Program.

ELIGIBLE DEPENDENTS

You must be enrolled for coverage yourself (as a “Participant”) under the applicable group health plans in order to request dependent coverage. Only an “eligible Dependent” as defined below may be enrolled in the group health plans:

An eligible Dependent includes any person who is a citizen, resident alien, or is otherwise legally present in the United States or in any other jurisdiction that the related Participant has been assigned by the Employer, and who is either:

1. The Participant's legal spouse according to the marriage laws of the state where the marriage was first solemnized or established.

NOTE: An eligible Dependent does not include a spouse who is legally separated or divorced from the Participant and has a court order or decree stating such from a court of competent jurisdiction.

2. A child who meets all of the following “Required Eligibility Conditions”:

(i) Is either a natural child, step-child, legally adopted child; or a child who has been Placed For Adoption with the Participant and for whom as part of such placement the Participant has a legal obligation for the partial or full support of such child, including providing coverage under the Plan pursuant to a written agreement; or a person for whom the Participant has been appointed the legal guardian by a court of competent jurisdiction prior to the person attaining nineteen (19) years of age; and

(ii) Is less than twenty-six (26) years of age. Eligibility may continue beyond twenty-six (26) years of age if such child is mentally handicapped / challenged or physically handicapped / challenged and has been enrolled as a covered Dependent under this Plan as of the date twenty-six (26) years is attained, provided that the child is incapable of self-supporting employment and is chiefly dependent upon the Participant for support and maintenance. Proof of incapacity must be furnished to the Plan Supervisor upon request, and additional proof may be required from time to time.

NOTE: An eligible Dependent does NOT include a domestic partner, a spouse of the Dependent child or a child of the Dependent child.

ENROLLING DEPENDENTS? HAVE THESE READY:

- Legal name
- Date of birth
- Social Security number
- For Qualifying Life Events, provide supporting documentation (e.g., marriage certificate, birth certificate, adoption papers, tax documents)

QUALIFYING LIFE EVENTS

Your benefit elections (medical, dental and vision) remain in effect for the entire plan year (July 1, 2026 - June 30, 2027). During each annual open enrollment period, you will have the opportunity to review your benefit elections and make changes for the coming year. Open Enrollment is the only time of the year that you can make changes to your enrollment selections, unless you have a Qualifying Life Event (QLE), as defined in the plan documents. QLEs include:

- Marriage, divorce or legal separation
- Gain or loss of an eligible dependent for reasons such as birth, adoption, court order, disability, death, marriage, or reaching the dependent child age limit
- Changes in your spouse's employment affecting benefit eligibility
- Changes in your spouse's benefit coverage with another employer that affects benefit eligibility
- Loss or gain of eligibility by dependent child(ren) under the Medicaid or CHIP program
- Loss or gain of coverage through the Marketplace

The change to your benefit elections must be consistent with the change in family status. For example, if you gain a new dependent due to birth, you may change your benefit elections to add that dependent. You have 30 days from the date of a family status change to make the appropriate change in the Benefits Portal and submit backup documentation (i.e. marriage certificate, court order, power of attorney, HIPAA certificate, hospital certificate) to Human Resources. Otherwise, you must wait until the next annual enrollment period to make a change to your elections. In most cases, your election will become effective the date the status change occurs, as well as applicable updates to your employee contributions.



GLOSSARY OF TERMS

CLAIM

A request for payment that you or your healthcare provider submits to your health plan when you acquire items or services you believe are covered.

COINSURANCE

The percentage of costs of a covered healthcare service you pay (20%, for example) after you've paid your deductible.

COPAYMENT/COPAY

A pre-determined (flat) fee an individual pays for healthcare services, in addition to what the health plan covers.

DEDUCTIBLE

The amount you pay for covered healthcare services before your health plan starts to pay. Any amounts that you meet in the in- and out-of-network deductibles cross accumulate.

DEPENDENT COVERAGE

Coverage for eligible family members of the Participant, such as spouses and children.

IN-NETWORK

A doctor or facility providing care and has negotiated a contract rate with your health plan PPO. You may not be balanced billed for amounts over the negotiated contract rate.

OUT-OF-NETWORK

A doctor or facility providing care and does not have a contract with your health plan PPO. You may be balance billed for amounts over the Maximum Eligible Expense (MEE) under the health plan.

OUT-OF-POCKET MAXIMUM

A cap or limit on the amount of money you have to pay for covered health care services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your health plan pays 100% of the costs of covered benefits. Amounts over the Maximum Eligible Expense (MEE) are not applied to your out-of-pocket maximum.

PRESCRIPTION DRUG COVERAGE

Helps pay for prescription drugs and medications.

PREVENTATIVE CARE

Routine healthcare, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease or other health problems.

PRIMARY CARE PHYSICIAN (PCP)

A physician who directly provides or coordinates a range of healthcare services for a patient.

SPECIALIST

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.



HOW TO ACCESS MEDICAL NETWORK PROVIDERS

1. Go to the Allegiance website: askallegiance.com/zenith/
2. Click on Employee/Employer Login (located on the top right-hand side of the page).
3. Enter your username and password and click Login (if you have not set up an account with Allegiance, you will need to set up an account by clicking on Register New User (located below the Login icon)).
4. Click on the Find a Provider icon located on the top of the page.
5. Click on the Find a Cigna Provider icon.
6. Enter an address, city or zip code and click on the icon that you would like to search by (ie. Doctor type, doctor name or health facilities and group practices).
7. There are 3 types of searches:
 - **Doctor by Type** – click the button and select a specialty or type of doctor (e.g., Internal Medicine, PCP, Ob/Gyn).
 - **Doctor by Name** – click on the button and enter the doctor's name.
 - **Health Facilities** – click on the button and enter health care facility name or select type of facility (e.g., Hospital/Medical Center, Urgent Care, Lab).
8. Click Continue as guest.
9. Click Continue.
10. Click on Open Access Plus icon and results will display.

HOW TO ACCESS & REQUEST YOUR MEDICAL BENEFIT ID CARDS

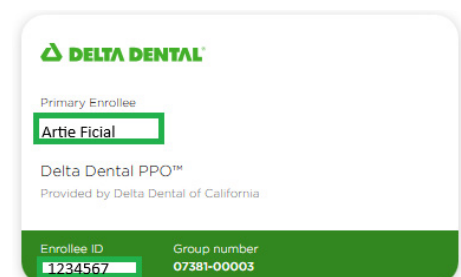
1. Go to the Allegiance website: askallegiance.com/zenith/
2. Click on Employee/Employer Login (located on the top right hand side of the page).
3. Enter your username and password and click Login (if you have not set up an account with Allegiance, you will need to set up an account by clicking on Register New User (located below the Login icon).
4. Click on the icon 2001060- ZENITH INSURANCE COMPANY located right below Health Account(s).
5. Click on ID Card located on the right-hand side of the page.
6. Click on Get ID Card Now.
7. Your ID Card will generate, and you will be able to view, download or print your ID card.
8. To download your ID card, click on the icon with the down arrow.
9. To print your ID card;
 - Click on the printer icon located on the top right-hand side of the page.
 - Select the destination where you would like the ID card to be printed to and click Print.



HOW TO ACCESS & REQUEST YOUR DENTAL BENEFIT ID CARDS

Accessing your dental coverage information is simple. Most dental providers can verify your eligibility directly with the carrier, so an ID card isn't required when you go in for care. However, you still have the option to view or download if you prefer to keep one on hand as Delta Dental does not mail out ID cards. The steps below walk you through how to access your card quickly and easily.

1. Log in to your Delta Dental account at deltadentalins.com
2. Click on Login located on the top right hand side of the page.
3. Enter your Username and click Next. If you do not have an account set up, click on Create an Account located right below the Next icon.
4. Click on Get ID card.
5. You have the option of printing or having the dental ID card emailed to you.



NOTICES

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996 (NEWBORN'S ACT)

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

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA, ALSO KNOWN AS JANET'S LAW)

Under WHCRA, group health plans, insurance companies and health maintenance organizations (HMOs) offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas. Call your Plan Administrator for more information.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

SPECIAL ENROLLMENT RIGHTS (HIPAA)

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SPECIAL ENROLLMENT RIGHTS CHIPRA – CHILDREN'S HEALTH INSURANCE PLAN

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances: You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.

You become eligible for a CHIP premium assistant subsidy under state Medicaid or CHIP (Children's Health Insurance Program). You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

COVERAGE EXTENSION RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

MICHELLE'S LAW

Michelle's Law permits seriously ill or injured college students to continue coverage under a group health plan when they must leave school on a full-time basis due to their injury or illness and would otherwise lose coverage. The continuation of coverage applies to a dependent child's leave of absence from (or other change in enrollment) a postsecondary educational institution (college or university) because of a serious illness or injury, while covered under a health plan. This would otherwise cause the child to lose dependent status under the terms of the plan. Coverage will be continued until:

1. One year from the start of the medically necessary leave of absence, or
2. The date on which the coverage would otherwise terminate under the terms of the health plan; whichever is earlier.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that:

The financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of

the individual, and (3) the manifestation of a disease or disorder in family members of such individual. GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record and may be disclosed to third parties only in very limited situations.

NO SURPRISES ACT

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible. What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network. "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

NOTICES

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
 - o Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
 - o Cover emergency services by out-of-network providers.
 - o Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - o Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

PREMIUM ASSISTANCE UNDER MEDICAID AND CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your 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://health.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 (Medicaid) & CHP+
Health First Colorado Website: <https://www.healthfirstcolorado.com/>
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

Florida – Medicaid
Website: <https://www.flmedicaidtprerecovery.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>
CHIPRA Phone: 678 564 1162 (Press 2)

Indiana – Medicaid
Health Insurance Premium Payment Program
Websites: <https://www.in.gov/medicaid/>
<http://www.in.gov/fssa/df/>
Phone: 1 800 403 0864
Member Services: 1 800 457 4584

Iowa – Medicaid & CHIP (Hawki)
Medicaid Website: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid>
Medicaid Phone: 1 800 338 8366
Hawki Website: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki>
Hawki Phone: 1 800 257 8563
HIPP Website: <https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp>
HIPP Phone: 1 888 346 9562

Kansas – Medicaid
Website: <https://www.kancare.ks.gov/>
Medicaid 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/kihhipp.aspx>
Phone: 1 855 459 6328
Email: KIHIPPPROGRAM@ky.gov
KCHIP Website: <https://kynect.ky.gov>
KCHIP Phone: 1 877 524 4718
Kentucky Medicaid Website: <https://chfs.ky.gov/agencies/dms>

Louisiana – Medicaid
Medicaid Website: <https://www.ldh.la.gov/healthy-louisiana>
Customer Service: 1 888 342 6207
Email: healthy@la.gov
LaHIPP Website: <https://www.ldh.la.gov/lahipp>
LaHIPP Phone: 1 877 697 6703
LaHIPP Email: La.HIPP@la.gov
LaHIPP Fax: 1 888 716 9787
Mailing Address: 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084

Maine – Medicaid
Enrollment Website: <https://www.mymaineconnection.gov/benefits/s/?language=en>
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

Massachusetts – Medicaid & 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
Website: <http://dhcfp.nv.gov>
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

NOTICES

Toll free HIP: 1 800 852 3345 ext. 15218
Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey – Medicaid & CHIP
Medicaid Website: <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 1 800 356 1561
CHIP Premium Assistance: 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 & CHIP
Website: <http://www.insureoklahoma.org>
Phone: 1 888 365 3742

Oregon – Medicaid & CHIP
Website: <http://healthcare.oregon.gov/Pages/index.aspx>
Phone: 1 800 699 9075

Pennsylvania – Medicaid & CHIP
Medicaid Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>
Medicaid Phone: 1 800 692 7462
CHIP Website: <https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx>
CHIP Phone: 1 800 986 KIDS (5437)

Rhode Island – Medicaid & CHIP
Website: <http://www.eohhs.ri.gov/>
Phone: 1 855 697 4347
Direct Line: 401 462 0311

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
HIP Program Website: <https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program>
Phone: 1 800 440 0493
Utah – Medicaid & CHIP
UPP Website: <https://medicaid.utah.gov/upp/>
Email: upp@utah.gov
Phone: 1 888 222 2542
Adult Expansion Website: <https://medicaid.utah.gov/expansion/>
Buyout Program: <https://medicaid.utah.gov/buyout-program/>
CHIP Website: <https://chip.utah.gov/>

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

Virginia – Medicaid & CHIP
FAMIS Select Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>
HIP Programs: <https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>
Phone: 1 800 432 5924

Washington – Medicaid
Website: <https://www.hca.wa.gov/>
Phone: 1 800 562 3022

West Virginia – Medicaid & CHIP
Websites: <https://dhhr.wv.gov/bms/http://mywvhipp.com/>
Medicaid Phone: 304 558 1700
CHIP Phone: 1 855 MyWVHIP (1 855 699 8447)

Wisconsin – Medicaid & CHIP
Website: <https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm>
Phone: 1 800 362 3002

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

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:
U.S. Department of Labor Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this

burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 2/28/2026)

OUR SERVICE PARTNERS CONTACTS

BENEFIT	PROVIDER	TELEPHONE	WEBSITE/EMAIL	GROUP NUMBER
Medical & Wellbeing				
Benefit Questions	The Benefits Team		Email Benefits@thezenith.com Information is found on Zip Benefits Page	
Medical	Allegiance	855.333.1007	askallegiance.com/zenith	2001060
Pharmacy	EmpiRx	877.934.2458	myempirxhealth.com/	Rx BIN: 024160 Rx PCN: 14032015 Rx GROUP: 19053
Dental	Delta Dental	888.335.8227	deltadentalins.com	07381-00003
Vision	Allegiance	855.333.1007	askallegiance.com/zenith	2001060
Patient Navigation & Advocacy	Rightway	833.950.4399	Email healthguide@rightwayhealthcare.com	
Omada Health	Omada	888.987.8337	omadahealth.com/omadaforallegiance	
Virtual Urgent Care	Recuro Health	855.673.2876	member.recurohealth.com	
Cancer Support	Cancer Expert Now	855.946.5735	cancerexpertnow.com/access Email carenavigator@onviv.com	
Wellness Program	Personify Health	866.941.2143	New Participants Registration: enroll.personifyhealth.com/#/ New Registration Passphrase: shiny-onion-58	Returning Participants: login.personifyhealth.com/
GI Care	Oshi Health	646.876.8455	oshihealth.com	
Women's Health	Visana	612.217.4967	visanahealth.com	
Heart Health	Heartbeat Health	646.586.9908	heartbeathealth.com	
Financial				
401(k)	Schwab Retirement Plan Services	800.724.7526	workplace.schwab.com	
Employee Share Purchase Plan	Computershare	888.887.6018	computershare.com/us Create an Account: na.equateplus.com Returning Participants: Single Sign On	
Flexible Spending Account	Allegiance	855.333.1007	askallegiance.com/zenith	509452
Life Insurance (Basic & Voluntary)	New York Life	800.362.4462	newyorklife.com	Basic: FLX965143 AD&D: OK966741 Voluntary: FLX965213
Long Term Disability	New York Life	800.362.4462	newyorklife.com	LK963571
Emotional				
Employee Assistance Program	ComPsych	800.272.7255	guidanceresources.com	
Virtual Mental Health	Brightside		brightside.com/askallegiance	
Additional Benefits				
Credit Union	Kinecta	800.854.9846	kinecta.org	
Healthy Weighs	Healthy Weighs		weightwatchers.com	
Medicare Resource	Via Benefits	833.858.1633	discover.viabenefits.com/thezenith	

