2024 BENEFITS

Employees

Incyte DIAGNOSTICS

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MEDICAL, DENTAL & VISION

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VOLUNTARY BENEFITS

IMPORTANT PLAN INFORMATION

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

GETTING STARTED

2024 BENEFITS

January 1, 2024, through December 31, 2024

MEDICARE PART D NOTICE

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the *Important Notices* section for more details.

Whether you're enrolling in benefits for the first time, nearing retirement, or somewhere in between, Incyte Diagnostics supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, life, disability, retirement benefits, and more.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Review the coverage and tools available to you to make the most of your benefits package.

WHO'S ELIGIBLE FOR BENEFITS?

Employees

You are eligible if you are an employee working 20 or more hours per week.

Employees with variable hours and seasonal schedules may be considered eligible for benefits. Please contact human resources to confirm eligibility

Eligible dependents

- Legally married spouse or domestic partner
- Natural, adopted or stepchildren up to age 26
- Children over age who are disabled and depend on you for support
- Children named in a Qualified Medical Child Support Order (QMCSO).

For additional information, please refer to the benefit booklets for each benefit.

When you can enroll

You can enroll in benefits as a new hire or during the annual open enrollment period. New hire coverage begins the first of the month on or following 30 days from hire date.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment (the one time each year that you can make changes to your benefits for any reason) unless you have a mid year qualifying event.

CHANGING YOUR BENEFITS

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in an individual's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit your change within 60 days after the event.

ENROLLING FOR BENEFITS

DO I NEED TO ENROLL?

If you do not have any changes to make to your 2024 benefits and you do not want to enroll in a Health savings account, Flexible Spending Account or dependent care account, **no action is required.**

ADP

ADP is an online system that enables you to make all your benefit decisions in one place.

Before you enroll

- Know the date of birth, social security number, and address for each dependent you will cover.
- Review your enrollment materials to understand your benefit options and costs for the coming year.

Getting started

- **LOG IN** to the ADP Portal
- **ADD** your personal and dependent information.
- **SELECT** your benefit plans for the coming year.
- **REVIEW** your choices and costs before finalizing.

MEDICAL

OUR PLANS

2024 Premera Medical Your Choice PPO Plan (HRA)

2024 Premera Medical Your Future High Deductible Health Plan (HSA)

WHICH PLAN IS RIGHT FOR YOU?

That depends on your healthcare needs and budget. Here are some considerations.

What are your usual healthcare needs?

Do you have frequent doctor or urgent care visits? Do you have a condition that requires a specialist? Do you take prescription medications? Compare how each plan covers the services you need most often.

Consider the bottom line

How much is the monthly payroll deduction? Do you have to meet a deductible? What is the out-of-pocket maximum? How much of the cost is covered by the plan? How much are any copayments for office visits, prescriptions, etc. All of these factors together affect your total cost for healthcare.

2024 PREMERA
MEDICAL YOUR CHOICE PPO PLAN (HRA)

PREMERA BLUE CROSS	In-Network Benefits	Out-of-Network Benefits
Annual Deductible	$2,000 per individual $6,000 family limit	$4,000 per individual $12,000 family limit
Accumulation Period	Time period to incur eligible expenses toward the deductible: Calendar year	
Annual Out-of-Pocket Maximum	$4,000 per individual $12,000 family limit	Unlimited
Office Visit	$35 copay then 100%	50% after deductible
Chiropractic	$35 copay then 100% (up to 12 visits per year)	50% after deductible (in-network limitations apply)
Lab and X-ray	100%	50% after deductible
Urgent Care	$35 copay then 100%	50% after deductible
Emergency Room	$100 copay then 80% after deductible (copay waived if admitted)	$100 copay then 80% after deductible (copay waived if admitted)
Hospitalization	80% after deductible	50% after deductible
Outpatient Surgery	80% after deductible	50% after deductible
VISION		
Copay	$35 copay then 100%	50% after deductible
Materials	Not covered	Not covered
Frequency	One visit every calendar year	
PRESCRIPTION DRUGS		
Out-of-Pocket Maximum	Prescriptions subject to medical out-of-pocket maximums	
Generic	**Preferred**: $15 copay then 100% **Non-Preferred**: Plan pays 70%	**Preferred**: $15 copay then 60%; **Non-Preferred**: In-network cost share then 40%
Brand Name	**Preferred**: $30 copay then 100% **Non-Preferred:** Plan pays 70%	**Preferred**: $30 copay then 60%; **Non-Preferred:** In-network cost share then 40%
Specialty	**Preferred**: $50 copay then 100% **Non-Preferred:** Plan pays 70%	**Preferred**: $50 copay then 60%; **Non-Preferred:** In-network cost share then 40%
Mail Order	90 days supply	Not applicable supply
Generic	**Preferred**: $37.50 copay then 100% **Non-Preferred:** Plan pays 70%	**Preferred**: Not covered **Non-Preferred:** Not covered
Brand Name	**Preferred**: $75 copay then 100% **Non-Preferred:** Plan pays 70%	**Preferred**: Not covered **Non-Preferred:** Not covered
Specialty	**Preferred**: $50 copay then 100% **Non-Preferred:** Plan pays 70%	**Preferred**: $50 copay then 60%; **Non-Preferred:** Not covered

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

CAN I HAVE BOTH AN HRA AND AN FSA?

Yes! You can have both an HRA and a healthcare Flexible Spending Account (FSA) at the same time, but you can't be reimbursed from both accounts for the same expense. Generally, the HRA is used first until the account is depleted.

Your "allowance" for healthcare expenses

Healthcare can be expensive. That's why Incyte Diagnostics provides eligible participants with an HRA to help pay your medical expenses. The HRA is administered by Peak1.

Here's how it works

- Each individual enrolled in the PPO medical plan must satisfy a $1,000 deductible before funds form the HRA are available.
- Once the $1,000 deductible has been met, the HRA will pay claims subject to the deductible up to $1,000 per individual.
- Once the individual has used all of the HRA benefit allocation, any remaining claims subject to the deductible will be the responsibility of the individual.
- Claim expenses are reimbursed and may require the submission of a receipt to issue payment.

Two reasons to love an HRA

1. **It's 100% employer-funded.** All contributions are made by Incyte Diagnostics. In fact, the rules prohibit employee contributions.
2. **It's tax-free.** HRA reimbursements are excluded from your gross income, so they are 100% tax-free.

Contributions

Incyte may contribute $1,000/year, per individual into your HRA.

2024 PREMERA
MEDICAL HIGH DEDUCTIBLE HEALTH PLAN (HSA)

PREMERA BLUE CROSS	In-Network Benefits	Out-of-Network Benefits
Annual Deductible	$1,600 employee coverage $3,200 family coverage	$3,000 employee coverage $6,000 family coverage
Accumulation Period	Time period to incur eligible expenses toward the deductible: Calendar year	
Annual Out-of-Pocket Maximum	$3,425 per individual $6,850 family limit	Unlimited
Office Visit	80% after deductible	50% after deductible
Chiropractic	80% after deductible (up to 12 visits per year)	50% after deductible (in-network limitations apply)
Lab and X-ray	80% after deductible	50% after deductible
Urgent Care	80% after deductible	50% after deductible
Emergency Room	80% after deductible	80% after deductible
Hospitalization	80% after deductible	50% after deductible
Outpatient Surgery	80% after deductible	50% after deductible
PRESCRIPTION DRUGS		
Deductible	Prescriptions subject to medical deductible	
Out-of-Pocket Maximum	Prescriptions subject to medical out-of-pocket maximums; Prescriptions subject to medical out-of-pocket maximums	
Generic	**Preferred**: 80% after deductible **Non-Preferred**: 80% after deductible	**Preferred**: 80% after deductible **Non-Preferred**: 80% after deductible
Brand Name	**Preferred**: 80% after deductible **Non-Preferred:** 80% after deductible	**Preferred**: 80% after deductible **Non-Preferred:** 80% after deductible
Specialty	**Preferred**: 80% after deductible **Non-Preferred:** 80% after deductible	**Preferred**: 80% after deductible **Non-Preferred:** 80% after deductible
Mail Order	90 days supply	Not applicable supply
Generic	**Preferred**: 80% after deductible **Non-Preferred:** 80% after deductible	**Preferred**: Not covered **Non-Preferred:** Not covered
Brand Name	**Preferred**: 80% after deductible **Non-Preferred:** 80% after deductible	**Preferred**: Not covered **Non-Preferred:** Not covered
Specialty	**Preferred**: 80% after deductible **Non-Preferred:** 80% after deductible	**Preferred**: Not covered **Non-Preferred:** Not covered

HEALTH SAVINGS ACCOUNT (HSA)

Click to play video

ARE YOU ELIGIBLE?

The HSA is not for everyone. You're eligible only if you are:

1. Enrolled in the Premera High Deductible Health Plan (HDHP)
2. Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
3. Not a tax dependent.
4. Not enrolled in a healthcare Flexible Spending Account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

A personal savings account for healthcare

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today and save for expenses you may have in the future.

How the HSA works

- Your HSA account is set up automatically after you enroll.
- To help you get started, Incyte Diagnostics makes a contribution to your HSA: up to $960 Annually
- You can contribute up to the limit set by the IRS (includes company amount).
- **2024 Limits:**
  Individual: $4,150 per year
  Family: $8,300 per year
  Are you age 55 You can contribute an additional $1,000 per year
- You can use your HSA to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.
- When you have a healthcare expense, submit a request for reimbursement with a receipt to Peak 1. You can use your HSA for eligible expenses, until you've used up your funds.
- Once your HSA reaches $1,000, you will have access to investment options to grow your HSA balance.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save it to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free, or for regular living expenses, taxable but no penalties.

HEALTHCARE FLEXIBLE SPENDING ACCOUNT (FSA)

Click to play video

ARE YOU ELIGIBLE?

You don't have to enroll in one of our medical plans to participate in the healthcare FSA. However, if you or your spouse are enrolled in a high deductible health plan (like our Your Future HDHP, you can only participate in the **Limited Purpose FSA** for dental and vision expenses.

Find out more

- Eligible Expenses – now include more over-the-counter items!
- Ineligible Expenses

Do you pay for dependent care?
A Dependent care FSA Helps you lower your taxable income while paying for childcare.

Dependent Care Limits: $5,000 per household or $2,500 for married individuals filing a separate tax return

Set aside healthcare dollars for the coming year

A healthcare FSA allows you to set aside tax-free money to pay for healthcare expenses you expect to have over the coming year.

How the Peak1 Flexible Spending Account works

- You estimate what you and your family's out-of-pocket costs will be for the coming year. Think about what out-of-pocket costs you expect to have for eligible expenses such as office visits, surgery, dental and vision expenses, prescriptions, even eligible drugstore items.
- You can contribute up to $3,200 (estimated for 2024) the annual limit set by the IRS. Contributions are deducted from your pay pre-tax, meaning no federal or state tax on that amount.
- During the year, you can use your FSA account to reimburse expenses through the submission of a receipt to Peak 1. Withdrawals are tax-free as long as they're for eligible healthcare expenses.

Estimate carefully!

If you don't spend all the money in your account, you can roll over up to $640 to use the following year. Any additional remaining balance will be forfeited. Funds can only be rolled over once.

FSA TAX SAVINGS EXAMPLE

$60,000 Annual Pay, with $1,500 FSA Contribution

$330 22% Federal income tax	**$115** 7.65% FICA tax	**$445** Annual FSA tax savings

$120,000 Annual Pay, with $2,750 FSA Contribution

$660 24% Federal income tax	**$210** 7.65% FICA tax	**$870** Annual FSA tax savings

Your tax savings may vary depending on tax filing status and other variables

POTENTIAL INSURANCE COST SAVINGS

Alliant
INDIVIDUAL HEALTH SOLUTIONS

With AIHS, affordable health insurance is within reach.

Schedule an appointment at alliantindividualhealthsolutions.com or call (877) 328-1195 to speak with a licensed insurance agent.

Your extended family and friends can also use AIHS at no charge!

Could your family get health insurance subsidies?

As part of our commitment to providing benefit options that meet your specific needs, we have partnered with Alliant Individual Health Solutions (AIHS). AIHS does not replace the company-sponsored group health insurance plans—rather, it expands options available to you and your dependents, with the opportunity for significant savings.

New rules make insurance more affordable for many

Changes in recent legislation could mean your dependents may now qualify for subsidies in the Affordable Care Act Marketplace (also called the Exchange), possibly lowering your family's healthcare premiums. The federal government has changed who may be eligible for Marketplace subsidies. If your family members previously were ineligible for Marketplace subsidies, they may now qualify.

How does it work?

The AIHS team can help you:

- Explore whether your dependents are eligible for subsidies.
- Learn whether an individual health plan could be a more affordable option than the company-sponsored group plans.
- Secure health coverage if you or your dependents are leaving a company plan.

AIHS may be able to help you find affordable coverage if:

- Your dependent child is turning 26 (making them no longer eligible for coverage under a company plan).
- You are retiring early (before Medicare benefits start at 65).
- Your spouse is younger than 65 (and not eligible for Medicare yet).
- You're leaving the company and want to explore options that may be more affordable than COBRA.

TURNING 65? UNDERSTAND YOUR MEDICARE OPTIONS

Alliant
MEDICARE SOLUTIONS
A Non-Government Entity

Alliant Medicare Solutions is a no-cost service available to you, your family members, and friends nearing age 65.

alliantmedicaresolutions.com

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Whether you retire or continue to work, choosing the right healthcare option is an important decision when you reach age 65

Most people become eligible for Medicare at age 65. When that happens, you'll probably have some time-sensitive decisions to make, based on your individual situation.

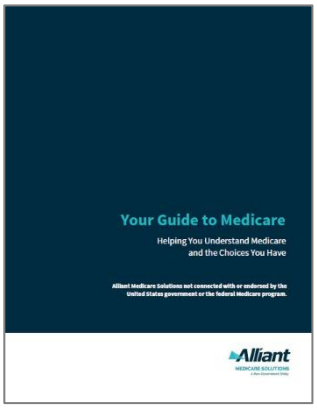
Introducing Alliant Medicare Solutions

Medicare can be complicated. Figuring out the rules—not to mention how Medicare works with or compares to your employer-provided medical coverage—can be a headache. That's why we are offering Alliant Medicare Solutions. The licensed insurance agents at AMS can help you understand Medicare, what is and isn't covered, and how to choose the best coverage for your situation.

How does it work?

1. Call Alliant Medicare Solutions at **(877) 888-0165** to speak to a licensed insurance agent. Have your current medical coverage information available when you call.
2. Discuss with Alliant Medicare Solutions your existing insurance coverage, your Medicare options, and which of those plans might work the best for you.
3. If Medicare is the best option, Alliant Medicare Solutions helps you enroll immediately or emails policy materials for you to review and enroll at a later date.

Find Out More



Your Guide to Medicare

Medicare 101 Video

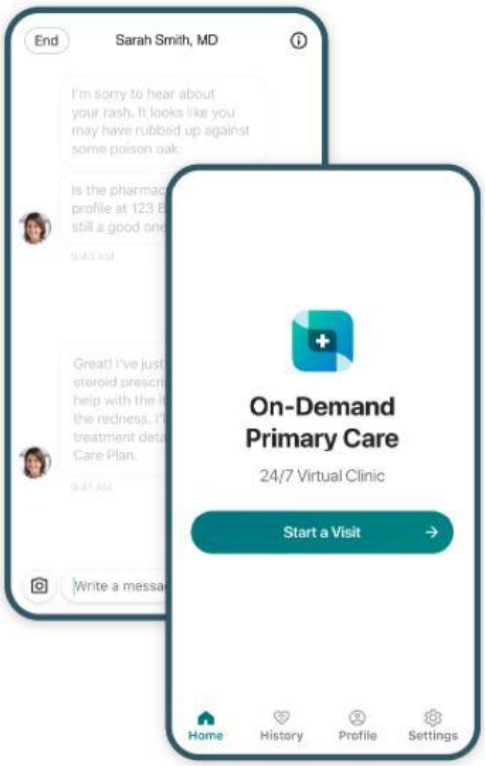
Social Security Planning Video

KNOW WHERE TO GO

Where you get medical care can have a significant impact on the cost. Here's a quick guide to help you know where to go, based on your condition, budget, and time.

Type	Appropriate for	Examples	Access	Cost
Nurseline 	Quick answers from a trained nurse	• Identifying symptoms • Decide if immediate care is needed • Home treatment options and advice	24/7	**$0**
98point6 	Simple non-emergency health conditions	• Cough & cold • Itchy or sore throat • Rashes • UTI & Yeast in	24/7	**$**
Online visit 	Many non-emergency health conditions	• Cold, flu, allergies • Headache, migraine • Skin conditions, rashes • Minor injuries • Mental health concerns	24/7	**$**
Office visit 	Routine medical care and overall health management	• Preventive care • Illnesses, injuries • Managing existing conditions	Office Hours	**$$**
Urgent care, walk-in clinic 	Non-life-threatening conditions requiring prompt attention	• Stitches • Sprains • Animal bites • Ear-nose-throat infections	Office Hours, or up to 24/7	**$$$**
Emergency room 	Life-threatening conditions requiring immediate medical expertise	• Suspected heart attack or stroke • Major bone breaks • Excessive bleeding • Severe pain • Difficulty breathing	24/7	**$$$$$**

ON-DEMAND TEXT BASED PRIMARY CARE 98point6



Ready when you are

We're here on-demand, 24/7, through the convenience of an app.

Private, anywhere access

Since visits are text-based*, you can get diagnosis and treatment discreetly, including ordering of prescriptions and labs**, whether you're at home, at work or on the go.

Doctor-driven, patient-focused

Central to our mission and supported by robust technology, our physicians have the passion and the means to deliver more empathetic, quality care that extends beyond a single visit.

Unlimited and affordable

Membership means you never need to wait or weigh the costs—simply address your health concerns as soon and as often as you need.

Sign up ›

Download on the App Store

GET IT ON Google Play

Our doctors are your partners.

98point6 board-certified physicians are with you every step of the way, saving time, cost and hassle while offering expert guidance and trusted reassurance along the right path to care.

Treating common conditions:

Cough & cold	Itchy or sore throat	Cold sores
Flu-like symptoms	Nausea	UTI & Yeast infections
Muscle sprains & strains	Seasonal allergies	Rashes
Stomach problems/flu	Pink eye	Acne

Acentra HEALTH | EMPLOYEE ASSISTANCE PROGRAM

Acentra Health Employee Assistance Program (EAP) is a complimentary service available to you through your employer. The EAP provides counseling sessions at no cost to you, as well as a wide variety of services to enhance overall wellbeing and support healthy work-life balance. Services and commonly addressed issues are described below. The program is completely confidential.
Call anytime to learn more or to get started.

EAP Products and Services

Immediate 24/7 Support & Guidance
Toll-Free Phone: 1.800.999.1077
EAP Website: www.EAPHelplink.com
Company Code: EAPNOW

Solutions-Focused Counseling
Whether you are dealing with stress, or issues with relationships, parenting, substance abuse, and more, we can help. Let us help connect you with a highly qualified counselor for in-person, phone, or video sessions. You are eligible for free confidential counseling sessions.

Legal & Financial Services
Legal and financial concerns can be stressful, complicated, and time-consuming. Reach out today for a free 30-minute consultation with an attorney or Money Coach, per each legal or financial matter, per year. Should you choose to retain the professional you will receive 25% off the regular rate.

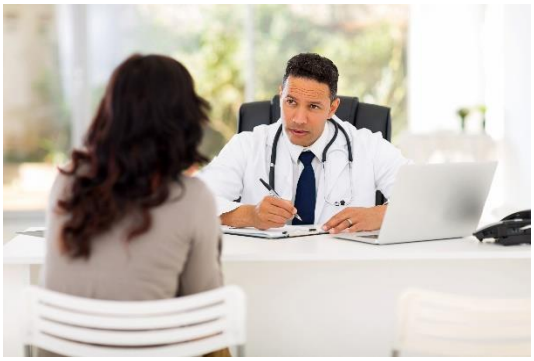
Caregiver Support Services
Are you looking for childcare, summer camps, afterschool activities, back-up care, or more? Need help finding referrals for assisted living facilities or in-home care for an older parent? We can help. Reach out to speak to one of our Childcare or Eldercare Specialists, available 24/7. In addition to referrals, they can offer expert advice and guidance tailored to your area of need.

Work-Life & Convenience Services
Let us do the leg work when it comes to researching fitness centers, colleges, adoption services, relocation services, volunteer opportunities, pet care, entertainment, doctors, home repair services, and so much more. Your time is too valuable; our research team is standing by to do the work for you.

Website Tools & Resources
Your EAP website is your one-stop resource for tools, articles, webinars, educational videos, legal forms, financial calculators, self-serve look-ups, and more. Your website and code is listed above.

Management and Organizational Services
Unlimited telephonic consultations are available to supervisors and administrators to provide solutions to complex individual and team issues, including ways to reduce conflict, and address performance and behavioral issues. We also provide immediate guidance related to the most effective response following a critical event in the workplace, in additional to coordinating any support services.

PREVENTIVE CARE SCREENING BENEFITS



TYPICAL SCREENINGS FOR ADULTS

- Blood pressure
- Cholesterol
- Diabetes
- Colorectal cancer screening
- Depression
- Mammograms
- OB/GYN screenings
- Prostate cancer screening
- Testicular exam

You take your car in for maintenance. Why not do the same for yourself?

Annual preventive checkups can help you and your doctor identify your baseline level of health and detect issues before they become serious.

What is Preventive Care?

The Affordable Care Act (ACA) requires health insurers to cover a set of preventive services at no cost to you, even if you haven't met your yearly deductible. The preventive care services you'll need to stay healthy vary by age, sex, and medical history.

Visit **cdc.gov/prevention** for recommended guidelines.

Preventive care is covered in full only when obtained from an IN-NETWORK provider.

Not all exams and tests are considered preventive

Exams performed by specialists are generally not considered preventive and may not be covered at 100 percent.

Additionally, certain screenings may be considered diagnostic, not preventive, based on your current medical condition. You may be responsible for paying all or a share of the cost for those services.

If you have a question about whether a service will be covered as preventive care, contact your medical plan.

Pharmacy Discount Resources

GoodRx

Additional pharmacy savings may be available

Good RX is a pharmacy savings program that offers discounts on some prescriptions. This can especially be true if a drug is not covered on the medical plan. Please keep in mind that if you choose to use these programs, your medical plan coverage will not apply. Ask your pharmacists about pricing differences when using programs such as GoodRX.

Website - www.goodrx.com

APP – Also available in the iTunes and google play app store

DENTAL

OUR PLANS

2024 Delta Dental Plan

2024 Willamette Dental Plan

Delta Dental of Washington

Willamette Dental Group

Why sign up for Dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

Dental insurance covers three types of treatments:

- **Preventive** care includes exams, cleanings and x-rays
- **Basic** care focuses on repair and restoration with services such as fillings, root canals, and gum disease treatment
- **Major** care goes further than basic and includes bridges, crowns and dentures

2024 DENTAL PLAN OFFERED BY DELTA DENTAL

Delta Dental provides you with access to a traditional dental PPO plan. This gives you the freedom to choose a provider from one of the largest networks in the state of Washington. The plan deductible applies to most services and benefits are capped at the annual plan maximum.

Delta Dental of Washington	In-Network Benefits	Out-of-Network Benefits
Annual Deductible	$50 per individual; $150 per family	$75 per individual $225 per family
Annual Plan Maximum	$2,000 per individual (applies to basic and major services only)	$1,500 per individual (in-network limitations apply; combined with in-network)
Diagnostic & Preventive	100%	100%
Basic Services	90% after deductible	50% after deductible
Major Services	50% after deductible	50% after deductible
Orthodontia	Not covered	Not covered

Healthy Start For Kids

100% coverage for most dental services through age 14

With this offering, Class I, II, and III services are covered at 100% which means no out-of-pocket costs when they visit a network dentist. These services include cleanings, exams, fillings, and crowns. Orthodontia and TMJ coverage remains at the group level.

No deductible and no annual maximum

There's no upfront cost before benefits kick in. There's also no cap to the amount of money the plan will pay towards dental care for Class I, II, and III services for children through age 14.

Greater access to dental care

This offering gives children access to the Delta Dental PPO℠ and Delta Dental Premier® networks. The coverage goes farthest with Delta Dental PPO and Premier acts like a safety net in case they're unable to find a PPO dentist nearby.

2024 DENTAL PLAN
OFFERED BY WILLAMETTE DENTAL GROUP

Willamette dental provides you with a managed care dental option. This plan has no annual limit, and most services only have a copayment apply. The trade off to having no annual maximum is a narrow network of providers.

Willamette Dental Group	**In-Network Benefits**
Annual Deductible	$0 per individual $0 per family
Annual Plan Maximum	Unlimited
Diagnostic & Preventive	$15-$30 copay then 100% (varies by services; see contract for fee schedule)
Basic Services	$15-$100 copay then 100% (varies by services; see contract for fee schedule)
Major Services	$150-$300 copay then 100% (varies by services; see contract for fee schedule)
Orthodontia	$1,500 copay then 100% (varies by services; see contract for fee schedule) Children: Covered Adults: Covered
Ortho Lifetime Max	Unlimited

Willamette office locations

Spokane – Northpointe	**Spokane – Valley**	**Coeur d'Alene**
9717 N Nevada Spokane, Wa 99218	9019 E Mission Ave Spokane Valley, Wa 99212	943 W Ironwood Drive Suite 200 Coeur d'Alene, Id 83814
General Dentistry	General Dentistry Endodontics Implants Orthodontics	General Dentistry Orthodontics

VISION

OUR PLANS

2024 VSP Voluntary Vision Plan

Why sign up for Vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

You'll even find discounts on services like LASIK and PRK, rebates on contact lenses, and other related services. Visit the plan's website to check out these extra savings.

2024 VSP VOLUNTARY VISION PLAN

Your vision checkup is fully covered after your Exam copay. After any Materials copay, the plan covers frames, lenses, and contacts as described below.

VSP Vision care for life	In-Network	Out-of-Network
Copay	**Exam:** $10 copay then 100% **Materials:** $25 copay then 100%	**Exam:** Reimbursed up to $50 **Materials:** $25 copay then 100% (see schedule below)
Frames	Up to $130 allowance, plus a 20% discount from the remaining balance	Reimbursed up to $70
Lenses	**Single Vision:** 100% of basic lens (materials copay applies) **Bifocal:** 100% of basic lens (materials copay applies) **Trifocal:** 100% of basic lens (materials copay applies)	**Single Vision:** Reimbursed up to $50 **Bifocal:** Reimbursed up to $75 **Trifocal**: Reimbursed up to $100
Contacts (Elective)	**Fitting & eval exam:** $60 copay then 100%; up to $130 allowance (copay waived; instead of eyeglasses)	Reimbursed up to $105 (in-network limitations apply)
Frequency	**Exam:** 1 x every 12 months from last date of service **Frames:** 1 x every 24 months from last date of service **Lenses**: 1 x every 12 months from last date of service **Contacts (Elective):** 1 x every 12 months from last date of service	**Exam:** In-network limitations apply **Frames:** In-network limitations apply **Lenses**: In-network limitations apply **Contacts (Elective):** In-network limitations apply

LONG-TERM DISABILITY INSURANCE (LTD)

3 THINGS TO KNOW ABOUT LTD INSURANCE

1. It can protect you from having to tap into your retirement savings.
2. You can use LTD benefits however you need, for housing, food, medical bills, etc.
3. Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-Term Disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders.

Payments may be reduced by state, federal, or private disability benefits you receive while disabled. Incyte Diagnostics pays the cost of this coverage.

2024 Unum Group LTD Plan

Monthly benefit amount	60% of covered monthly earnings up to a maximum of $5,000
Benefits begin	After 60 days of disability
Maximum payment period	To SSNRA/RBD

VOLUNTARY INDIVIDUAL DISABILITY INSURANCE (IDI)

Individual disability insurance is a great benefit for those who need to cover income above what is offered by the standard LTD plan.

IDI enrollment occurs during a special enrollment period, for more information contact HR.

IDI provides an extra layer to protect your income

The following features are part of your IDI plan and determine, in part when and how it works.

- **Benefit period** – the IDI benefit period is up to age 67. For disabilities occurring between ages 65 and 75, the maximum benefit period is 24 months. For disabilities occurring after age 75, the maximum benefit period is 12 months.
- **Elimination period** – your plan's waiting period is 90 days.
- **Non-Cancellable Policy** – as long as your premiums are paid on time, your policy cannot be cancelled, and your premium amount is guaranteed until you reach the non-can expiration date. If your policy is issued prior to your 63rd birthday, the non-can expiration date is your 67th birthday. If it's issued after your 63rd birthday, the non-can expiration date is five years from Policy effective date.

This policy provides the following monthly disability benefits:

- **Total Disability Benefit** - The policy pays benefits for the duration of the benefit period if you are totally disabled in your occupation, which means you are unable to work in your occupation, not working in another occupation, and are under the care of a doctor.
- **Benefit for Residual Disability** - You must be under a doctor's care to be eligible for this benefit, which can pay for up to the end of your benefit period. You don't have to be totally disabled to be eligible, but you must still either lose time (due to injury or sickness) from your job or be unable to perform some of your job requirements and incur a loss of earnings of at least 20%.
- **Work Incentive Benefit (WIB)** - feature of the Residual Disability Benefit that provides short-term monthly benefits during the first 12 months of a compensable residual disability. These short-term incentive benefits are equal to the difference between your pre-disability earnings and your current earnings, for up to 100% income replacement, subject to your maximum monthly benefit amount.
- **Recovery Benefit** - Provides a benefit for 6 months if you fully recover, return to full-time work in your occupation but you continue to lose earned income due to your prior disability. This provision pays a benefit while you re-establish your earnings base. The amount you get is based on the percentage of earnings you lose.

VOLUNTARY LIFE INSURANCE

GUARANTEED ISSUE

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

Protecting those you leave behind

Voluntary Life Insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or child(ren) if you purchase coverage for yourself.

2024 Unum Group Voluntary Life and AD&D Plan

Employee	Increments of $10,000 up to Lesser of 5 x covered annual earnings or $500,000. Guaranteed issue of $110,000.
Spouse	Increments of $5,000 up to Lesser of 100% of employee amount or $500,000. Guaranteed issue of $25,000.
Child(ren)	Increments of $2,000 (age may affect benefit) up to Lesser of 100% of employee amount or $10,000 (age may affect benefit). Guaranteed issue of $10,000.

Voluntary Life Rates (Per $1,000)	
<25	$0.090
25-29	$0.090
30-34	$0.113
35-39	$0.156
40-44	$0.198
45-49	$0.314
50-54	$0.530
55-59	$0.809
60-64	$1.092
65-69	$2.124
70-74	$3.930
75+	$3.930
Child(ren) (Per unit) – Birth to age 26	$0.240
Voluntary AD&D Rates (Per $1,000)	
Employee	$0.017
Spouse	$0.017
Child(ren)	$0.017

VOLUNTARY HEALTH-RELATED PLANS

THINGS TO CONSIDER

Your medical plan helps cover the cost of illness, but a serious or long-lasting medical crisis often involves additional expenses and may affect your ability to bring home a full paycheck. These plans provide you with resources to help you get by while there are additional strains on your finances.

Accident Insurance

Accident Insurance from UNUM helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

Critical Illness Insurance

Critical illness insurance from UNUM can help fill a financial gap if you experience a serious illness such as cancer, heart attack or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed. Children are automatically enrolled with employees; spouses need to enroll separately.

If you purchase Critical Illness after your initial eligibility period, you will need to submit Evidence of Insurability with additional information about your health in order for the insurance company to approve the amount of coverage.

Hospital Indemnity Insurance

Hospital indemnity insurance from UNUM can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide. This plan also includes a wellness benefit of up to $75 per calendar year if a health screening test is performed. All full list of covered screening tests can be found in the policy.

VOLUNTARY RATES

Accident Monthly Cost	
Employee	$8.68
Employee + Spouse	$14.92
Employee + Children	$19.67
Employee +Spouse + Children	$25.91

Critical Illness Monthly Cost – Per $10,000 Employee and Per $5,000 Spouse		
Age	Employee + Children Cost	Spouse Cost
<25	$1.20	$0.60
25-29	$1.80	$0.90
30-34	$2.50	$1.25
35-39	$3.70	$1.85
40-44	$5.20	$2.60
45-49	$7.30	$3.65
50-54	$10.00	$5.00
55-59	$14.10	$7.05
60-64	$20.30	$10.15
65-69	$29.70	$14.85
70-74	$45.00	$22.50
75-79	$63.30	$31.65
80-84	$84.70	$42.35
85+	$124.90	$62.45

Hospital Indemnity	
Employee	$29.60
Employee + Spouse	$55.75
Employee + Children	$42.47
Employee + Spouse + Children	$68.62

SHORT-TERM DISABILITY INSURANCE (STD)

ONLY THOSE MAKING $130,000+ IN OR, WA ARE ELIGIBLE. All employees in ID and MT are eligible.

EXPECT THE UNEXPECTED

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

Voluntary STD Benefits

Short-Term Disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability.

2024 Unum Group STD Plan

Weekly benefit amount	60% of covered weekly earnings up to a maximum of $2,500
Benefits begin	After 7 days of disability due to accident or 7 days due to sickness
Maximum payment period	13th week of disability (based on first day you are disabled, not when benefits begin)

Monthly Rates	Employees in OR/WA earning $130,000 or more	Employees working outside of OR/WA
<25	$0.231	$0.747
25-29	$0.610	$1.982
30-34	$1.106	$3.596
35-39	$0.833	$2.702
40-44	$0.348	$1.120
45-49	$0.247	$0.786
50-54	$0.316	$1.00
55-59	$0.378	$1.195
60-64	$0.515	$1.629
65-69	$0.621	$1.963
70-74	$0.621	$1.963
75+	$0.621	$1.963

IMPORTANT PLAN INFORMATION

In this section, you'll find important plan information, including:

- Your medical, dental and vision benefit contributions for 2024
- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually
- A Benefits Glossary to help you understand important insurance terms.

YOUR MONTHLY BENEFIT COSTS

The total amount that you pay for your benefits coverage depends on the plans you choose, how many dependents you cover, and for medical coverage, how much you earn. Your healthcare costs are deducted from your pay on a pre-tax basis — before federal, state, and social security taxes are calculated — so you pay less in taxes.

MEDICAL

Premera 2000 PPO Plan With HRA

	Employee Cost	Incyte Cost	Total Cost
EMPLOYEE ONLY	$220.00	$612.97	$832.97
EMPLOYEE + SP	$550.00	$1,324.16	$1,874.16
EMPLOYEE + CH(REN)	$420.00	$1,037.70	$1,457.70
FAMILY	$750.00	$1,748.88	$2,498.88

Premera 1500 HSA Plan

	Employee Cost	Incyte Cost	Total Cost
EMPLOYEE ONLY	$60.00	$703.85	$763.85
EMPLOYEE + SP	$400.00	$1,318.67	$1,718.67
EMPLOYEE + CH(REN)	$290.00	$1,046.76	$1,336.76
FAMILY	$600.00	$1,691.56	$2,291.56

Please note that unless your domestic partner is your tax dependent as defined by the IRS, contributions for domestic partner coverage must be made after-tax. Similarly, the company contribution toward coverage for your domestic partner and his/her dependents will be reported as taxable income on your W-2. Contact your tax advisor for more details on how this tax treatment applies to you. Notify InCyte Pathology, PS dba Incyte Diagnostics if your domestic partner is your tax dependent.

Spousal Surcharge

Effective January 1, 2024, spouses with access to medical coverage through their own employer will now be subject to a surcharge if you choose to enroll them on our medical plan. The monthly surcharge will be $100/month.

Note: Spouses without access to an employer medical plan can continue to be covered on our plan without the additional surcharge.

YOUR MONTHLY BENEFIT COSTS (continued)

Delta Dental	Employee Cost	Incyte Cost	Total Cost
EMPLOYEE ONLY	$0.00	$59.09	$59.09
EMPLOYEE + SPOUSE	$63.04	$59.09	$122.13
EMPLOYEE + CHILD (REN)	$68.87	$59.09	$127.96
EMPLOYEE + SPOUSE + CHILD (REN)	$132.38	$59.09	$191.47

Willamette Dental	Employee Cost	Incyte Cost	Total Cost
EMPLOYEE ONLY	$14.26	$59.09	$73.35
EMPLOYEE + SPOUSE	$88.46	$59.09	$147.55
EMPLOYEE + CHILD (REN)	$94.31	$59.09	$153.40
EMPLOYEE + SPOUSE + CHILD (REN)	$162.11	$59.09	$221.20

VISION – Employee Paid

Vision Service Plan	Employee Cost	Incyte Cost	Total Cost
EMPLOYEE ONLY	$7.98	$0.00	$7.98
EMPLOYEE + SPOUSE	$12.77	$0.00	$12.77
EMPLOYEE + CHILD (REN)	$13.04	$0.00	$13.04
EMPLOYEE + SPOUSE + CHILD (REN)	$21.02	$0.00	$21.02

PLAN CONTACTS

MEDICAL, DENTAL & VISION

Premera Blue Cross
Medical
Policy # 1000119
www.Premera.com
Member Services
(800)722-1471

Delta Dental
Policy # 01533
www.deltadentalWA.com
Member Services
(800) 554-1907

Willamette Dental
Policy # WA90
www.willamettedental.com
Member Services
(855) 433-6825

Vision Service Plan (VSP)
Policy # 30003476
www.vsp.com
Member Services
(800) 877-7195

HSA, HRA, FSA, DCA, COBRA

Peak 1
www.peak1.com
Member Services
(866) 315-1777

LIFE AND AD&D, STD & LTD

UNUM
www.unum.com

Life/AD&D Claims
(800) 455-0402

Disability Claims
(877) 851-7637

Accident, Hospital & Critical Illness

UNUM
www.unum.com
Member Services
(800) 635-5597

EAP

UNUM LifeBlance
www.unum.com/lifeblance
Member Services
(800) 854-1446

Acentra Health
www.EAPHelplink.com
Company Code: EAPNOW
(800) 999-1077

Human Resources

HR@incdx.com
(509) 892-2700

GLOSSARY

-A-

AD&D Insurance
An insurance plan that pays a benefit to you or your beneficiary if you suffer from loss of a limb, speech, sight, or hearing, or if you have a fatal accident.

Allowed Amount
The maximum amount your plan will pay for a covered healthcare service.

Ambulatory Surgery Center (ASC)
A healthcare facility that specializes in same-day surgical procedures such as cataracts, colonoscopies, upper GI endoscopy, orthopedic surgery, and more.

Annual Limit
A cap on the benefits your plan will pay in a year. Limits may be placed on particular services such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services or on the number of visits that will be covered for a particular service.
After an annual limit is reached, you must pay all associated health care costs for the rest of the plan year.

-B-

Balance Billing
In-network providers are not allowed to bill you for more than the plan's allowable charge, but out-of-network providers are. This is called balance billing. For example, if the provider's fee is $100 but the plan's allowable charge is only $70, an out-of-network provider may bill YOU for the $30 difference (the balance).

Beneficiary
The person (or persons) that you name to be paid a benefit should you die. Beneficiaries are requested for life, AD&D, and retirement plans. You must name your beneficiary in advance.

Brand Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine.

-C-

COBRA
A federal law that may allow you to temporarily continue healthcare coverage after your employment ends, based on certain qualifying events. If you elect COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Claim
A request for payment that you or your health care provider submits to your healthcare plan after you receive services that may be covered.

Coinsurance
Your share of the cost of a healthcare visit or service. Coinsurance is expressed as a percentage and always adds up to 100%. For example, if the plan pays 70%, your coinsurance responsibility is 30% of the cost. If your plan has a deductible, you pay 100% of the cost until you meet your deductible amount.

Copayment
A flat fee you pay for some healthcare services, for example, a doctor's office visit. You pay the copayment (sometimes called a copay) at the time you receive care. In most cases, copays do not count toward the deductible.

-D-

Deductible
The amount of healthcare expenses you have to pay for with your own money before your health plan will pay. The deductible does not apply to preventive care and certain other services.

Family coverage may have an ***aggregate*** or ***embedded*** deductible. Aggregate means your family must meet the entire family deductible before any individual expenses are covered. Embedded means the plan begins to make payments for an individual member as soon as they reach their individual deductible.

Dental Basic Services
Services such as fillings, routine extractions and some oral surgery procedures.

Dental Diagnostic & Preventive Generally includes routine cleanings, oral exams, x-rays, and fluoride treatments.
Most plans limit preventive exams and cleanings to two times a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays and onlays.

Dependent Care Flexible Spending Account (FSA)
An arrangement through your employer that lets you pay for eligible child and elder care expenses with tax-free dollars. Eligible expenses include day care, before and after-school programs, preschool, and summer day camp for children under age 13. Also included is care for a spouse or other dependent who lives with you and is physically incapable of self-care.

-E-

Eligible Expense
A service or product that is covered by your plan. Your plan will not cover any of the cost if the expense is not eligible.

Excluded Service
A service that your health plan doesn't pay for or cover.

-F-

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a drug list.

-G-

Generic Drug
A drug that has the same active ingredients as a brand name drug, but is sold under a different name. For example, Atorvastatin is the generic name for medicines with the same formula as Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

-H-

Health Reimbursement Account (HRA) An account funded by an employer that reimburses employees, tax-free, for qualified medical expenses up to a maximum amount per year. Sometimes called Health Reimbursement Arrangements.

Healthcare Flexible Spending Account (FSA)
A health account through your employer that lets you pay for many out-of-pocket medical expenses with tax-free dollars. Eligible expenses include insurance copayments and deductibles, qualified prescription drugs, insulin, and medical devices, and some over-the-counter items.

High Deductible Health Plan (HDHP) A medical plan with a higher deductible than a traditional insurance plan. The monthly premium is usually lower, but you pay more health care costs (the deductible) before the insurance company starts to pay its share. A high deductible plan (HDHP) may make you eligible for a health savings account (HSA) that allows you to pay for certain medical expenses with money free from federal taxes.

GLOSSARY

-I-

In-Network
In-network providers and services contract with your healthcare plan and will usually be the lowest cost option. Check your plan's website to find doctors, hospitals, labs, and pharmacies. Out-of-network services will cost more, or may not be covered.

-L-

Life Insurance
An insurance plan that pays your beneficiary a lump sum if you die.

Long Term Disability Insurance
Insurance that replaces a portion of your income if you are unable to work due to a debilitating illness, serious injury, or mental disorder. Long term disability generally starts after a 90-day waiting period.

-M-

Mail Order
A feature of a medical or prescription drug plan where medicines you take routinely can be delivered by mail in a 90-day supply.

-O-

Open Enrollment
The time of year when you can change the benefit plans you are enrolled in and the dependents you cover. Open enrollment is held one time each year. Outside of open enrollment, you can only make changes if you have certain events in your life, like getting married or adding a new baby or child in the family.

Out-of-Network
Out-of-network providers (doctors, hospitals, labs, etc.) cost you more because they are not contracted with your plan and are not obligated to limit their maximum fees. Some plans, such as HMOs and EPOs, do not cover out-of- network services at all.

Out-of-Pocket Cost
A healthcare expense you are responsible for paying with your own money, whether from your bank account, credit card, or from a health account such as an HSA, FSA or HRA.

Out-of-Pocket Maximum
Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most remaining eligible expenses for the rest of the plan year.

Family coverage may have an *aggregate* or *embedded* maximum. Aggregate means your family must meet the entire family out-of-pocket maximum before the plan pays 100% for any member. Embedded means the plan will cover 100% for an individual member as soon as they reach their individual maximum.

Outpatient Care
Care from a hospital that doesn't require you to stay overnight.

-P-

Participating Pharmacy
A pharmacy that contracts with your medical or drug plan and will usually result in the lowest cost for prescription medications.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
Each health plan has a preferred drug list that includes prescription medicines based on an evaluation of effectiveness and cost. Another name for this list is a "formulary." The plan may charge more for non-preferred drugs or for brand name drugs that have generic versions. Drugs that are not on the preferred drug list may not be covered.

Preventive Care Services
Routine healthcare visits that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems. Many preventive care services are fully covered. Check with your health plan in advance if you have questions about whether a preventive service is covered.

Primary Care Provider (PCP)
The main doctor you consult for healthcare issues. Some medical plans require members to name a specific doctor as their PCP, and require care and referrals to be directed or approved by that provider.

-S-

Short Term Disability Insurance
Insurance that replaces a portion of your income if you are temporarily unable to work due to surgery and recovery time, a prolonged illness or injury, or pregnancy issues and childbirth recovery.

-T-

Telehealth / Telemedicine / Teledoc
A virtual visit to a doctor using video chat on a computer, tablet or smartphone. Telehealth visits can be used for many common, non-serious illnesses and injuries and are available 24/7. Many health plans and medical groups provide telehealth services at no cost or for much less than an office visit.

-U-

UCR (Usual, Customary, and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that care is needed right away, but not so severe it requires emergency room care. Treatment at an urgent care center generally costs much less than an emergency room visit.

-V-

Vaccinations
Treatment to prevent common illnesses such as flu, pneumonia, measles, polio, meningitis, shingles, and other diseases. Also called immunizations.

Voluntary Benefit
An optional benefit plan offered by your employer for which you pay the entire premium, usually through payroll deduction.

IMPORTANT PLAN INFORMATION

HEALTH PLAN NOTICES

These notices must be provided to plan participants on an annual basis and are located at the end of the booklet.

- **Medicare Part D Notice:** Describes options to access prescription drug coverage for Medicare eligible individuals
- **Women's Health and Cancer Rights Act:** Describes benefits available to those that will or have undergone a mastectomy
- **Newborns' and Mothers' Health Protection Act:** Describes the rights of mother and newborn to stay in the hospital 48-96 hours after delivery
- **HIPAA Notice of Special Enrollment Rights:** Describes when you can enroll yourself and/or dependents in health coverage outside of open enrollment
- **HIPAA Notice of Privacy Practices:** Describes how health information about you may be used and disclosed
- **Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP):** Describes availability of premium assistance for Medicaid eligible dependents.

COBRA CONTINUATION COVERAGE

You and/or your dependents may have the right to continue coverage after you lose eligibility under the terms of our health plan. Upon enrollment, you and your dependents receive a COBRA Initial Notice that outlines the circumstances under which continued coverage is available and your obligations to notify the plan when you or your dependents experience a qualifying event. Please review this notice carefully to make sure you understand your rights and obligations.

ANNUAL NOTICES

Medicare Part D Notice

Important Notice from Incyte Diagnostics About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Incyte Diagnostics 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. Incyte Diagnostics has determined that the prescription drug coverage offered by the Premera Blue Cross 2000 PPO and 1500 HSA Medical plans are, 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 Incyte Diagnostics coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under Premera Blue Cross 2000 PPO and 1500 HSA Medical plans are creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your Incyte Diagnostics prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 Incyte Diagnostics 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 Incyte Diagnostics 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 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 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:	01/01/2024
Name of Entity:	Incyte Diagnostics
Contact-Position/Office:	Human Resources
Address:	13103 E Mansfield Ave, Spokane Valley WA, 99216
Phone Number:	(509) 892-2726

Women's Health and Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call your plan administrator at (800) 722-1471.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at (800) 722-1471.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in Incyte Diagnostics' health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in Incyte Diagnostics' health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30-day timeframe, coverage will be effective on the date of birth, adoption or placement for adoption date. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in Incyte Diagnostics' health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for Incyte Diagnostics describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Human Resources.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility—

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program | Website: http://myakhipp.com/ | Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: 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 (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943 | State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/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.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
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ | Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ | Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/ime/members | Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki | Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | HIPP Phone: 1-888-346-9562
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | 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://kidshealth.ky.gov/Pages/index.aspx | 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: 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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | 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. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html | Phone: 1-800-701-0710
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: 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.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx | 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: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Medicaid Website: https://medicaid.utah.gov/ | CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or 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/ or 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, 2023, or for more information on special enrollment rights, contact either:

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

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.12% in 2023 (8.39% in 2024) of your modified adjusted household income.

The 'No Surprises' Rules

The "No Surprises" rules protect you from surprise medical bills in situations where you can't easily choose a provider who's in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you're no longer in need of emergency care. These are called "post-stabilization services." You shouldn't get this notice and consent form if you're getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren't required to sign the form and shouldn't sign the form if you didn't have a choice of health care provider or facility before scheduling care. If you don't sign, you may have to reschedule your care with a provider or facility in your health plan's network.

View a sample notice and consent form (PDF).

This applies to you if you're a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

General Notice of COBRA Continuation Coverage Rights

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;

- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Human Resources.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Name of Entity:	Incyte Diagnostics
Contact-Position/Office:	Human Resources
Address:	13103 E Mansfield Ave, Spokane Valley WA, 99216
Phone Number:	(509) 892-2726

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.