Radiology Ltd.

2026 Employee Benefits

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We all work together to make Radiology Ltd. a success, and our teamwork extends to your benefits. Your health and wellbeing are important to us, so we provide benefit options to make your and your family's lives better. Together, let's invest in you. Read over this guide for details on your 2026 benefits from A to Z. If you have questions, your Human Resources department is here to help.

See **page 27** for important information concerning Medicare Part D coverage.

In this Guide, we use the term company to refer to Radiology Ltd. This Guide is intended to describe the eligibility requirements, enrollment procedures and coverage effective dates for the benefits offered by the company. It is not a legal plan document and does not imply a guarantee of employment or a continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

Eligibility & Enrollment

Radiology Ltd. offers a variety of benefits to support your and your family's needs. Choose options that cover what's important to your unique lifestyle.

Eligibility

If you are a full-time employee of Radiology Ltd. who is regularly scheduled to work 30 hours per week, you are eligible to participate in the medical, dental, vision, life and disability plans and additional benefits.

When does coverage begin?

Your elections are effective on the first following your date of hire. If your date of hire coincides with the first of the month coverage begins on date of hire. New hires must enroll within 30 days of when they begin working. You won't be able to change your benefits until the next enrollment period unless you experience a Qualifying Life Event.

Eligible Dependents

Dependents eligible for coverage in the Radiology Ltd. benefits plans include:

- Your legal spouse.
- Children up to age 26 (includes birth children, stepchildren, legally adopted children, children placed for adoption, foster children and children for whom legal guardianship has been awarded to you or your spouse).
- Dependent children 26 or more years old, unmarried and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical disability which arose while the child was covered as a dependent under this plan (periodic certification may be required).

Verification of dependent eligibility will be required upon enrollment.

Working Spouse Surcharge

If your spouse has access to medical coverage through their employer, and you add them to your Radiology Ltd. medical coverage, you will pay a monthly $150 spouse surcharge. If your spouse does not work, works part-time, is self-employed, is not eligible for coverage, has lost coverage as an active employee but has been offered COBRA or is covered by Medicare, the spousal surcharge does not apply. Note: The company reserves the right to verify if your spouse is provided coverage elsewhere.

Tobacco/Vaping Surcharge

If you smoke or vape and enroll in the Radiology Ltd. medical plan, you will pay a monthly $100 tobacco surcharge. Get support at no cost with QuitlineNC at 844-862-7848.

Thoughts & Tips: You cannot change your benefit selections during the plan year unless you have a Qualifying Life Event, such as marriage and/or the birth or adoption of a child.

Enroll now. You've got one shot!

What are Qualifying Life Events?

Most people know you can change your benefits when you start a new job or during Open Enrollment. But did you know that changes in your life may permit you to update your coverage at other points in the year? Qualifying Life Events (QLEs) determined by the IRS could allow you to enroll in health insurance or change your elections outside of the annual time.

When a Qualifying Life Event occurs, you have 30 days to request changes to your coverage. Keep in mind your change in coverage must be consistent with your change in status.

Questions regarding specific life events and your ability to request changes should be directed to Radiology Ltd.'s Human Resources. Don't miss out on a chance to update your benefits!

Common qualifying events include:

- A change in your employment status from full time to part time, or part time to full time, resulting in a gain or loss of eligibility
- A change in your legal marital status (marriage, divorce or legal separation)
- Entitlement to Medicare or Medicaid
- A change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Eligibility for coverage through the Marketplace
- A change in your spouse's employment status (resulting in a loss or gain of coverage)
- Changes in your address or location that may affect the coverage for which you are eligible

Some lesser-known qualifying events are:

- Turning 26 and losing coverage through a parent's plan
- Changes that make you no longer eligible for Medicaid or the Children's Health Insurance Program (CHIP)
- Death in the family (leading to change in dependents or loss of coverage)

Preparing for Open Enrollment

As a committed partner in your health, Radiology Ltd. absorbs a significant amount of your benefit costs. Your contributions for medical, dental and vision benefits are deducted on a pre-tax basis, lessening your tax liability. Please note that employee contributions vary depending on level of coverage. Typically, the more coverage you have, the higher your portion.

You may select any combination of medical, dental and/or vision plan coverage. For example, you could select medical coverage for you and your entire family, but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of Radiology Ltd., must elect coverage for yourself in order to elect any dependent coverage.

Open Enrollment To-Do

Update your personal information.

If you've experienced a Qualifying Life Event in the last year, you may need to change your elections or update your details.

Double-check covered and restricted medications.

If you make any changes to your plan, consider how it affects your prescription coverage.

Review available plans' deductibles.

Take a look at your options – if you foresee a lot of medical needs this year, you might want a lower deductible. If not, you could switch to a higher deductible and enjoy lower premiums.

Consider your HSA or FSA.

An HSA or FSA can help cover healthcare costs including dental and vision services and prescriptions. Adding one of these accounts to your benefits can help with your long-term financial goals – and your employer may help contribute.

Check to see if your pharmacy is in-network.

Going in-network often saves you money. Check for any plan changes to make sure your favorite pharmacy is still your best bet and is covered in-network.

How to Pick a Plan

Which plan is right for you? When deciding, consider any medical needs you foresee for the upcoming plan year, your overall health, and any medications you currently take.

How does an HDHP (High Deductible Health Plan) work?

You'll pay for the full cost of non-preventive medical services until you reach your deductible.

You can also use a Health Savings Account in conjunction, which provides a safety net for unexpected medical costs and tax advantages.

Preventive Care

Most health plans are required to cover a set of preventive services — at no cost to you!

Screening tests and routine checkups are considered preventive, which means they're often paid at 100%. Keep up to date with your primary care physician to save time and money and keep yourself healthier in the long run. Under the U.S. Patient Protection and Affordable Care Act (PPACA), some common covered services include:

- Wellness visits, physicals and standard immunizations
- Screenings for blood pressure, cancer, cholesterol, depression, obesity and diabetes
- Pediatric screenings for hearing, vision, obesity and developmental disorders
- Anemia screenings, breastfeeding support and pumps for pregnant and nursing women
- Iron supplements (for children ages 6 to 12 months at risk for anemia)

Take advantage of these covered services. However, remember that diagnostic care to identify health risks is covered according to plan benefits, even if done during a preventive care visit. This means if your doctor finds a new condition or potential risk during your appointment, the services may be billed as diagnostic medicine and result in some out-of-pocket costs. Read over your benefit summary to see what specific preventive services are provided to you.

Medical Benefits

Medical benefits are provided through Cigna. Choose the plan that works best for your life. Consider the physician networks, premiums and out-of-pocket costs for each plan. Keep in mind your choice is effective for the entire 2026 plan year, unless you have a Qualifying Life Event.

Medical Premiums

Premium contributions for medical are deducted from your paycheck on a pre-tax basis. Your level of coverage determines your bimonthly contributions.

	CIGNA HDHP LOCALPLUS BRONZE - 5,000/10,000 100%	CIGNA HDHP OAP SILVER - 3,500/7,000 80%	CIGNA HDHP OAP GOLD - 3,500/7,000 100%
BIMONTHLY CONTRIBUTIONS			
EMPLOYEE ONLY	$15.18	$47.25	$77.66
EMPLOYEE + SPOUSE	$250.45	$306.18	$368.88
EMPLOYEE + CHILD(REN)	$161.29	$207.78	$260.07
EMPLOYEE + FAMILY	$361.13	$428.37	$503.94

How to Find a Provider

Visit www.mycigna.com or call Customer Care at 800-244-6224 for a current list of Cigna network providers.

Our Plans are Self-Funded

Our medical and Rx plans are self-funded, which means that the company bears the financial risk of the plan. Rather than paying insurance premiums to an insurance carrier as with fully insured plans, the company pays fixed costs for using the insurance carrier's network of physicians and variable costs for the members' claims. Self-insured plans allow for more control and freedom in plan design. Together, the company and employees share the cost for healthcare.

Thoughts & Tips: Most preventive care offered by an in-network physician is covered at 100%.

Medical Benefits

Medical Plan Summary

This chart summarizes the 2026 medical coverage provided by Cigna. All covered services are subject to medical necessity as determined by the plan. Please be aware that all out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	CIGNA HDHP LOCALPLUS BRONZE - 5,000/10,000 100%		CIGNA HDHP OAP SILVER - 3,500/7,000 80%		CIGNA HDHP OAP GOLD - 3,500/7,000 100%	
NETWORK	LOCALPLUS		OPEN ACCESS PLUS		OPEN ACCESS PLUS	
DEDUCTIBLE						
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
INDIVIDUAL	$5,000	$5,000	$3,500	$3,500	$3,500	$3,500
FAMILY	$10,000	$10,000	$7,000	$7,000	$7,000	$7,000
COINSURANCE (YOUR COST)	0%*	50%*	20%*	50%*	0%*	50%*
ANNUAL OUT-OF-POCKET MAXIMUM (INCLUDES DEDUCTIBLE)						
INDIVIDUAL	$5,000	$10,000	$6,000	$12,000	$5,000	$10,000
FAMILY	$10,000	$20,000	$12,000	$24,000	$10,000	$20,000
COPAYS/COINSURANCE						
PREVENTIVE CARE	0%	50%	0%	50%	0%	50%
PRIMARY CARE	0%*	50%*	20%*	50%*	0%*	50%*
SPECIALIST SERVICES	0%*	50%*	20%*	50%*	0%*	50%*
URGENT CARE	0%*	50%*	20%*	50%*	0%*	50%*
DIAGNOSTIC CARE	0%*	50%*	20%*	50%*	0%*	50%*
EMERGENCY ROOM	$100 access fee then 0%*		$100 access fee then 20%*		$100 access fee then 0%*	

*After Deductible

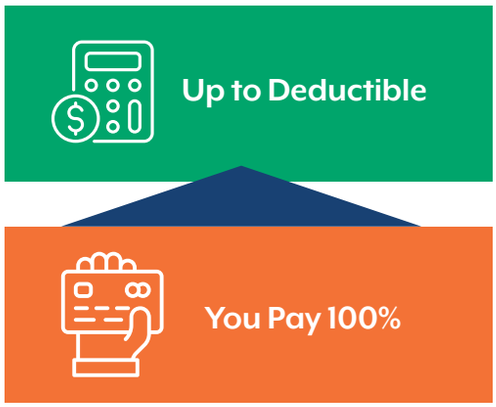
The plan has an embedded deductible, which means members must meet their individual deductible before covered services will be paid under the plan. If dependents are covered, you also have a combined family deductible. Once the family deductible is met, covered services will be paid according to the benefits for all family members. No member may contribute more than the individual deductible amount to the family deductible amount. In-network services are credited to your in-network deductible and out-of-network services are credited to your out-of-network deductible.

Out-of-Pocket Costs

Know Before You Go: Paying for Services

Deductible

The amount you must pay for covered services before your insurance starts paying its portion.



Copay

The fixed amount you pay for healthcare services at the time you receive them.

Coinsurance

Your percentage of the cost of a covered service. If your office visit is $100 and your coinsurance is 20% (and you've met your deductible but not your out-of-pocket maximum), your payment would be $20.

Up to the Out-of-Pocket Maximum

After Deductible is reached

Out-of-Pocket Maximum

The most you will pay during the plan year before your insurance begins to pay 100% of the allowed amount.

Where to Go for Care

You think you may be sick, but your primary care physician is booked through the end of the month. You have a question about the side effects of a new medication, but the pharmacy is closed. Instead of immediately choosing an expensive trip to the emergency room or relying on questionable information from the internet, take a look below at various care centers and resources and the types of care they provide.

PRIMARY CARE CENTER

When would I use this?
You need routine care or treatment for a current health issue. Your primary doctor knows you and your health history, can access your medical records, provide routine care, and manage your medications.

What type of care would they provide?*
- Routine checkups
- Immunizations
- Preventive services
- Manage your general health

What are the costs and time considerations?**
- Often requires a copay and/or coinsurance
- Normally requires an appointment
- Usually little wait time with scheduled appointment

HEALTH INFORMATION LINE 800-Cigna24

When would I use this?
You need a quick answer to a health issue that does not require immediate medical treatment or a physician visit.

What type of care would they provide?*
Answers to questions regarding:
- Symptoms
- Medications and side effects
- Self-care home treatments
- When to seek care

What are the costs and time considerations?**
- Nurse lines are usually available 24 hours a day, 7 days a week.
- This service is usually free as part of your medical insurance.

TELEMEDICINE

When would I use this?
You need care for minor illnesses and ailments, but would prefer not to leave home. These services are available by phone and online (via webcam).

What type of care would they provide?*
- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Sinus problems

What are the costs and time considerations?**
- There is usually a first-time consultation fee and a flat fee or copay for any visit thereafter.
- Access to care is usually immediate.
- Some states may not allow for prescriptions through telemedicine or virtual visits.

DO YOUR HOMEWORK

What may seem like an urgent care center could actually be a standalone ER. These newer facilities come with a higher price tag, so ask for clarification if the word "emergency" appears in the company name.

URGENT CARE CENTER

When would I use this?
You need care quickly, but it is not a true emergency. Urgent care centers offer treatment for non-life-threatening injuries or illnesses.

What type of care would they provide?*
- Strains, sprains
- Minor broken bones (e.g., finger)
- Minor infections
- Minor burns
- X-rays

What are the costs and time considerations?**
- Often requires a copay and/or coinsurance that is usually higher than an office visit
- Walk-in patients welcome, but waiting periods may be longer as patients with more urgent needs will be treated first

EMERGENCY ROOM

What are the costs and time considerations?**
- Often requires a much higher copay and/or coinsurance
- Open 24/7, but waiting periods may be longer because patients with life-threatening emergencies will be treated first

When would I use this?
You need immediate treatment for a serious life-threatening condition. If a situation seems life threatening, call 911 or your local emergency number right away.

What type of care would they provide?*
- Heavy bleeding
- Chest pain
- Major burns
- Spinal injuries
- Severe head injury
- Broken bones

*This is a sample list of services and may not be all-inclusive. **Costs and time information represent averages only and are not tied to a specific condition or treatment.

Virtual Medicine

When you're sick, the last thing you want to do is leave the cozy comfort of your home. Or sometimes you're just too on the go to pop in for a visit. Virtual medicine is a convenient and easy way to talk to a doctor fast.

Telemedicine

We provide a telemedicine benefit through MDLive to you and your dependents. MDLive offers on-demand access to board-certified doctors through online video, telephone or secure email. Telemedicine is useful for after-hours non-emergency care, when your primary care doctor is unavailable, if you need prescriptions or refills or if you're traveling. Please note that some states do not allow physicians to prescribe medications via telemedicine. For more information, visit myCigna.com.

MDLive doctors can treat many medical conditions, including:

- Virtual Annual Checkup screening
- Primary Care visits
- Urgent Care
- Behavioral Care visits
- Dermatology

Virtual Visits

A virtual visit with MDLive lets you see and talk to a doctor from your phone, tablet or computer without an appointment. Most visits take about 10-15 minutes, and doctors can write a prescription (in participating states). Try a virtual visit when your doctor is not available or you're traveling.

Doctors can diagnose and treat a wide range of non-emergency medical conditions, including:

- Bladder infection/ Urinary tract infection
- Bronchitis
- Cold/flu
- Pink eye
- Rash
- Sinus problems
- Sore throat
- Stomachache

Access Virtual Visits

Visit myCigna.com to request a virtual visit. Once you register and request a consult, you will pay your portion of the service costs according to your medical plan, and then enter a virtual waiting room. During your visit you can talk to a doctor about your health concerns, symptoms and treatment options.

Virtual visits aren't good for conditions requiring an exam or test, complex or chronic problems, or emergencies, including sprains or broken bones.

Speak with a medical provider from anywhere within minutes.

STEP 1: Visit your MDLive website: www.MDLive.me/group/radiology

STEP 2: Locate the "Talk to a doctor or nurse 24/7" callout and click "Connect Now.".

Pharmacy Benefits

Prescription Drug Coverage for Medical Plans

Our Prescription Drug Program is coordinated through Cigna. That means you will only have one ID card for both medical care and prescriptions. Information on your benefits coverage and a list of network pharmacies is available online at www.mycigna.com or by calling the Customer Care number on your ID card. Your cost is determined by the tier assigned to the prescription drug product. Products are assigned as Generic, Preferred, Non-Preferred or Specialty Drugs. You may find information on your benefits coverage and search for network pharmacies by logging on to www.mycigna.com or by calling the Customer Care number on your ID card.

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	IN-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
RETAIL RX (30-DAY SUPPLY)					
YOUR COST					
GENERIC	0%*	20%*	50%*	0%*	50%*
PREFERRED	0%*	20%*	50%*	0%*	50%*
NON-PREFERRED	0%*	20%*	50%*	0%*	50%*
SPECIALTY DRUGS	0%*	20%*	50%*	0%*	50%*
MAIL ORDER RX (90-DAY SUPPLY)					
YOUR COST					
GENERIC	0%*	20%*	Not Covered	0%*	Not Covered
PREFERRED	0%*	20%*	Not Covered	0%*	Not Covered
NON-PREFERRED	0%*	20%*	Not Covered	0%*	Not Covered
SPECIALTY DRUGS	0%*	20%*	Not Covered	0%*	Not Covered

*After Deductible

Generic Drugs

Looking to save money on medication costs? You've most likely heard that generic prescription drugs are a more affordable option. Generic drugs are versions of brand-name drugs with the exact same dosage, intended use, side effects, route of administration, risks, safety and strength. Because they are the same medicine, generic drugs are just as effective as brand-name drugs and undergo the same rigid FDA standards. But on average, **a generic version costs 80% to 85% less than the brand-name equivalent.** To find out if there is a generic equivalent for your brand-name drug, visit www.fda.gov.

Note: Apps such as GoodRx and RxSaver let you compare prices of prescription drugs and find possible discounts. If you use these tools, make sure to check the price against the cost through your insurance to get the best deal. Note that these discounts can't be combined with your benefit plan's coverage. As a result, if you choose to use a discount card from an app such as GoodRx or RxSaver, the amount you pay will not count toward your deductible or out-of-pocket maximum under the benefit plan.

Health Savings Account

Need funds to help cover out-of-pocket healthcare expenses? Consider a Health Savings Account (HSA). An HSA is a personal healthcare bank account used to pay for qualified medical expenses and funded by you, and in some cases your employer too. HSA contributions and withdrawals for qualified healthcare expenses are tax-free. You must be enrolled in an HDHP (High Deductible Health Plan) to participate.

Your HSA can be used for qualified expenses for you, your spouse, and/or tax dependent(s), even if they're not covered by your plan. If you are not currently enrolled in an HDHP but you have unused HSA funds from a previous account, those funds can still be used for qualified expenses.

HSA Bank will issue you a debit card with direct access to your account balance. Use your debit card to pay for qualified medical expenses — no need to submit receipts for reimbursement. Like a regular debit card, you must have a balance in your HSA account to use the card.

Thoughts & Tips: Because HSA funds never expire, contributing your annual maximum to your HSA can help you save to pay for healthcare expenses tax-free after retirement.

Unused funds roll over annually

Eligible expenses include doctors' visits, eye exams, prescription expenses, laser eye surgery, menstrual products, PPE, over-the-counter medications, and more. Visit IRS Publication 502 on www.irs.gov for a complete list.

Eligibility

You are eligible to contribute to an HSA if:

- You are enrolled in an HSA-eligible High Deductible Health Plan.
- You are not covered by your spouse's or parent's non-HDHP.
- You or your spouse does not have a Healthcare Flexible Spending Account or Health Reimbursement Account.
- You are not eligible to be claimed as a dependent on someone else's tax return.
- You are not enrolled in Medicare or TRICARE.
- You have not received Department of Veterans Affairs medical benefits in the past 90 days for non-service-related care. (Service-related care will not be taken into consideration.)

You Own Your HSA

Your HSA is a personal bank account that you own and manage. You decide how much you contribute, when to use the money for medical services and when to reimburse yourself. You can save and roll over HSA funds to the next year if you don't spend them all in the calendar year. You can even let funds accumulate year over year to use for eligible expenses in retirement. HSA funds are also portable if you change plans or jobs. There are no vesting requirements (you own all contributed HSA funds immediately) or forfeiture provisions (you keep all HSA funds whether you leave the company or retire).

How to Enroll

If you elect an HDHP with Radiology Ltd., you will be automatically enrolled in the HSA via the HRIS system. However, in order to receive company funds, you must activate the account by submitting enrollment materials to the HSA provider, HSA Bank.

HSAs and Taxes

HSA contributions are made through payroll deduction on a pre-tax basis when you open an account with HSA Bank. The money in your HSA (including interest and investment earnings) grows tax-free. When the funds are used for qualified medical expenses, they are spent tax-free.*

Per IRS regulations, if HSA funds are used for purposes other than qualified medical expenses and you are younger than age 65, you must pay federal income tax on the amount withdrawn, plus a 20% penalty tax. This is why it's important to know what medical expenses qualify for HSA use and to keep track of where you spend your HSA funds.

*State income taxes are also waived on HSA contributions in almost all states.

HSA Funding Limits

The IRS places an annual limit on the maximum amount that can be contributed to HSAs. For 2026, contributions (which include any employer contribution) are limited to the following:

HSA FUNDING LIMITS	
EMPLOYEE	$4,400
FAMILY	$8,750
CATCH-UP CONTRIBUTION (AGES 55+)	$1,000

Radiology Ltd. contributes up to $1,000 to your HSA annually. Your initial HSA employer contribution of $500 is deposited at the end of January. You can earn an additional $500 by completing a health survey by September 30. The survey form is available in Paycom for your convenience. Survey contribution funding will take place on the last payroll of the following month after completion of the survey.

For new hires first eligible between July 1 and September 30 you will receive an initial employer contribution of $250 and can earn a $250 contribution for completing a health survey. New hires first eligible October 1 through December 31 will not receive an employer HSA contribution in 2026.

EMPLOYER HSA CONTRIBUTION	
EMPLOYEE	Up to $1,000
FAMILY	Up to $1,000

HSA contributions over the IRS annual contribution limits are not tax deductible and are generally subject to a 6% excise tax.

If you've contributed too much to your HSA this year, you have two options:

- Remove the excess contributions and the net income attributable to the excess contribution before you file your federal income tax return (including extensions). You'll pay income taxes on the excess removed but won't have to pay a penalty tax.
- Leave the excess contributions in your HSA and pay 6% excise tax on them. Next year consider contributing less than the annual limit to your HSA.

The Radiology Ltd. HSA is established with HSA Bank. You may be able to roll over funds from another HSA. For more enrollment information, contact Human Resources or visit www.hsabank.com.

Flexible Spending Accounts

Take control of your spending! A Flexible Spending Account (FSA) is a special tax-free account you put money into to pay for certain out-of-pocket expenses.

Healthcare Flexible Spending Account

You can contribute up to $3.400 annually for qualified medical expenses (deductibles, copays, coinsurance, menstrual products, PPE, over-the-counter medications, etc.) with pre-tax dollars, which reduces your taxable income and increases your take-home pay. You can even pay for eligible expenses with an FSA debit card at the same time you receive them — no waiting for reimbursement.

Dependent Care Flexible Spending Account

In addition to the Healthcare FSA, you may opt to participate in the Dependent Care FSA — even if you don't elect any other benefits. Set aside pre-tax funds into a Dependent Care FSA for expenses associated with caring for elderly or child dependents. Unlike the Healthcare FSA, reimbursement from your Dependent Care FSA is limited to the total amount that is currently deposited in your account.

- With the Dependent Care FSA, you can set aside up to $7,500 to pay for child or elder care expenses on a pre-tax basis.
- Eligible dependents include children under 13 and a spouse or other individual who is physically or mentally incapable of self-care and has the same principal place of residence as the employee for more than half the year.
- You must provide the tax identification number or Social Security number of the party providing care to be reimbursed.

This account covers dependent daycare expenses that are necessary for you and your spouse to work or attend school full time. Eligible expenses include:

- In-home babysitting services (not provided by a dependent)
- Care of a preschool child by a licensed nursery or daycare provider
- Before- and after-school care
- Day camp
- In-house dependent daycare

Due to federal regulations, expenses for your domestic partner and your domestic partner's children may not be reimbursed under the FSA programs. Check with your tax advisor to determine if any exceptions apply.

Thoughts & Tips: The Dependent Care FSA is not to be used for medical expenses, nor is it the same as electing medical coverage for dependents.

Using the Account

Use your FSA debit card at doctor and dentist offices, pharmacies, and vision service providers. It cannot be used at locations that do not offer services under the plan, unless the provider has also complied with IRS regulations. The transaction will be denied if you use the card at an ineligible location.

Submit a claim form along with the required documentation. Contact HealthEquity with reimbursement questions. If you need to submit a receipt, HealthEquity will notify you. Always save receipts for your records.

While FSA debit cards allow you to pay for services at point of sale, they do not remove the IRS regulations for substantiation. Always keep receipts and Explanation of Benefits (EOBs) for any debit card charges in case you need to prove an expense was eligible. Without proof an expense was valid, your card could be turned off and the expense deemed taxable.

General Rules

The IRS has the following rules for Healthcare and Dependent Care FSAs:

- Expenses must occur during the 2026 plan year.
- Funds cannot be transferred between FSAs.
- You are not permitted to claim the same expenses on both your federal income taxes and Dependent Care FSA.
- You must "use it or lose it" — any unused funds will be forfeited. An expense incurred between 1/1/2026 and 12/31/2026 must be submitted for reimbursement by 3/15/2026.
- You cannot change your FSA election in the middle of the plan year without a Qualifying Life Event.
- Terminated employees have ninety (90) days following termination to submit FSA claims for reimbursement.
- Those considered highly compensated employees (family gross earnings were $160,000 or more last year) may have different FSA contribution limits. Visit www.irs.gov for more info.

FSA vs HSA

Flexible Spending Accounts		Health Savings Accounts
Your employer owns your FSA. If you leave your employer, you lose access to the account unless you have a COBRA right.	OWNERSHIP	You own your HSA. It is a savings account in your name, and you always have access to the funds, even if you change jobs.
You can elect a Healthcare FSA even if you waive other coverage. You cannot make changes to your contribution during the Plan Year without a Qualifying Life Event. You cannot be enrolled in both a Healthcare FSA and an HSA.	ELIGIBILITY & ENROLLMENT	You must be enrolled in a Qualified HDHP to contribute money to your HSA. You cannot be covered by a spouse's non-High Deductible plan or a spouse's FSA or enrolled in Medicare or TRICARE. You can change your contribution at any time during the Plan Year.
FSA contributions are tax-free via payroll deduction. Funds are spent tax-free when used for qualified expenses.	TAXATION	HSA contributions are tax-free; the account grows tax-free; and funds are spent tax-free on qualified expenses.
You can contribute up to $3,400 in 2026 to an FSA. This amount may be increased annually.	CONTRIBUTIONS	Both you and your employer can contribute up to $4,400 in 2026 (up to $8,750 for families). Ages 55+ can make an annual $1,000 "catchup" HSA contribution.
Some plans include an FSA debit card to pay for eligible expenses. If not, you pay up front and submit receipts for reimbursement.	PAYMENT	Many HSAs include a debit card to pay for qualified expenses directly. Alternatively, you can save funds for future expenses or retirement.
Any unclaimed funds at the end of the year are forfeited. Exceptions might include an additional 2.5-month grace period for expenses to be incurred and reimbursed, or an allowed rollover amount.	ROLLOVER OR GRACE PERIOD	HSA funds roll over from year to year. The account is portable and may be used for future qualified expenses — even in retirement years.
Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, and vision care. A full list is available at www.irs.gov.	QUALIFIED EXPENSES	Physician services, hospital services, prescriptions, menstrual products, PPE, over-the-counter medications, dental care, vision care, Medicare Part D plans, COBRA premiums, and long-term care premiums. A full list is available at www.irs.gov.
Dependent Care FSA (pre-tax dollars can be used for elder or child dependent care) and Limited Use FSA (used to pay for eligible dental and vision expenses).	OTHER TYPES	There is only one type of HSA.

Please refer to your summary plan description or plan certificate for your plan's specific FSA or HSA benefits.

Dental Benefits

Brushing your teeth and flossing are great, but don't forget to visit the dentist too! Radiology Ltd. offers affordable plan options for routine care and beyond. Coverage is available from Cigna.

Network Dentists

If you use a dentist who doesn't participate in your plan's network, your out-of-pocket costs will be higher, and you are subject to any charges beyond the Reasonable and Customary (R&C). To find a network dentist, visit Cigna at www.mycigna.com.

Dental Premiums

Premium contributions for dental are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your bimonthly premium.

Dental Plan Summary

This chart summarizes the 2026 dental coverage provided by Cigna.

	DENTAL PPO - LOW PLAN CIGNA DPPO ADVANTAGE	DENTAL PPO - HIGH PLAN CIGNA DPPO ADVANTAGE	DENTAL HMO (W1-V9) CIGNA DENTAL CARE ACCESS
BIMONTHLY CONTRIBUTIONS			
EMPLOYEE	$8.63	$19.83	$0.00
EMPLOYEE + SPOUSE	$17.21	$38.29	$0.00
EMPLOYEE + CHILD(REN)	$21.81	$38.60	$0.00
FAMILY	$33.29	$55.61	$0.00
ANNUAL DEDUCTIBLE			
INDIVIDUAL	$50	No Deductible	N/A
FAMILY	$150	No Deductible	N/A
ANNUAL MAXIMUM			
PER PERSON	$1,000	$1,500	Unlimited
COVERED SERVICES			
PREVENTIVE SERVICES (cleanings, exams, x-rays)	0%; no deductible	0%; no deductible	No charge
BASIC SERVICES (fillings, root canal therapy, oral surgery)	20% after deductible	10%; no deductible	See Schedule
MAJOR SERVICES (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	40% after deductible	40%; no deductible	See Schedule
ORTHODONTIA	Children to age 26	Children to age 26	Adult and Children
ORTHODONTIA LIFETIME MAX	$1,000	$1,000	25% off normal and customary fees

Thoughts & Tips: Only 60% of adults ages 20 to 64 have been to the dentist in the past year. Take advantage of your dental coverage to keep your smile healthy.

Vision Benefits

Don't wear glasses? Even you shouldn't skip an annual eye exam! Radiology Ltd. provides you and your family access to quality vision care with a comprehensive vision benefit through Cigna.

Vision Premiums

Premium contributions for vision are deducted from your paycheck on a pre-tax basis. Your tier of coverage determines your bimonthly premium.

Vision Plan Summary

This chart summarizes the 2026 vision coverage provided by Cigna.

	VOLUNTARY VISION BENEFITS		
BIMONTHLY CONTRIBUTIONS			
EMPLOYEE ONLY	$1.84		
EMPLOYEE + SPOUSE	$5.18		
EMPLOYEE + CHILD(REN)	$5.25		
EMPLOYEE + FAMILY	$9.27		
	IN-NETWORK (ANY CIGNA-VSP PROVIDER)	OUT-OF-NETWORK (ANY QUALIFIED NON-NETWORK PROVIDER OF YOUR CHOICE)	FREQUENCY
EXAMS			
COPAY	$10 copay	Up to $45 reimbursement	Once every 12 months
LENSES			
SINGLE VISION	Covered in full*	$32 allowance*	Once every 12 months
BIFOCAL	Covered in full*	$55 allowance*	
TRIFOCAL	Covered in full*	$65 allowance*	
LENTICULAR	Covered in full*	$80 allowance*	
CONTACTS (IN LIEU OF LENSES AND FRAMES)			
FITTING AND EVALUATION**	$10 copay	N/A	Once every 12 months
ELECTIVE	$130 allowance	$105 allowance	
MEDICALLY NECESSARY	Covered in full	$210 allowance	
FRAMES			
COPAY	$10 copay	N/A	Once every 12 months
ALLOWANCE	$130	$71 allowance	

*After Copay
**Fitting and Evaluation fee applied to contact lens allowance.

Thoughts & Tips: More than 150 million Americans use corrective eyewear to compensate for refractive errors.

Survivor Benefits

It's difficult to think about what would happen if something ever happened to you, but it's important to have a plan in place to make sure your family is provided for. Survivor benefits provide financial protection and security in the event of death or serious accident. Securing Life insurance now ensures your family will be protected for the future.

Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Radiology Ltd. provides employees with Basic Life and AD&D insurance as part of your basic coverage through New York Life (formerly Cigna), which guarantees that loved ones, such as a spouse or other designated survivor(s), continue to receive part of an employee's benefits after death.

Your Basic Life and AD&D insurance benefit is $50,000. If you are a full-time employee, you automatically receive Life and AD&D insurance even if you elect to waive other coverage.

If death is the result of an accident, your beneficiary will receive an additional amount equal to your basic life insurance coverage. If you are dismembered (such as loss of sight in an eye, loss of a hand, foot, limb, hearing, speech, etc.), benefits will be paid to you as a percentage of the basic life amount.

What's a beneficiary?

Your beneficiary is the person you designate to receive your Life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by Radiology Ltd. You receive the benefit payment for a dependent's death under the New York Life (formerly Cigna) insurance.

Name a primary and contingent beneficiary to make your intentions clear. Make sure to indicate their full name, address, Social Security number, relationship, date of birth and distribution percentage. Please note that in most states, benefit payments cannot be made to a minor. If you elect to designate a minor as beneficiary, all proceeds may be held under the beneficiary's name and will earn interest until the minor reaches majority age at 18. If you need assistance, contact Human Resources or your own legal counsel.

Voluntary Life and AD&D Insurance

Life and AD&D benefits are an important part of your family's financial security. The basic benefits provided to you by Radiology Ltd. may not be enough to cover expenses in a time of need. Therefore, extra coverage is available to protect you and your family. Eligible employees may purchase additional Voluntary Life and AD&D insurance. Premiums are paid through payroll deductions. In order to elect Voluntary Life Insurance for a dependent, you (the Employee) have to first elect it for yourself.

BASIC EMPLOYEE LIFE/AD&D	
COVERAGE AMOUNT	$50,000
WHO PAYS	Radiology Ltd.
BENEFITS PAYABLE	In the event of your death, while covered under the plan.
EVIDENCE OF INSURABILITY (EOI) REQUIRED	No
VOLUNTARY EMPLOYEE LIFE	
COVERAGE AMOUNT	Up to five times your salary in increments of $10,000
WHO PAYS	Employee
BENEFITS PAYABLE	If you die while covered under the plan. This benefit is in addition to your Basic Life benefit.
MAXIMUM BENEFIT	The lesser of 5 times your annual salary or $500,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	For amounts above $180,000
VOLUNTARY SPOUSE LIFE	
COVERAGE AMOUNT	Up to 50% of employee election in increments of $5,000
WHO PAYS	Employee
BENEFITS PAYABLE	If your spouse dies while covered under the plan.
MAXIMUM BENEFIT	$250,000
EVIDENCE OF INSURABILITY (EOI) REQUIRED	For amounts above $50,000
VOLUNTARY CHILD LIFE	
COVERAGE AMOUNT	$1,000 increments up to $10,000
WHO PAYS	Employee
BENEFITS PAYABLE	If your dependent dies while covered under the plan.
MAXIMUM BENEFIT	$10,000
VOLUNTARY EMPLOYEE AD&D	
COVERAGE AMOUNT	Amount equal to voluntary life insurance
WHO PAYS	Employee
BENEFITS PAYABLE	If you die as the result of an unintentional accident while covered under the plan, or as the result of certain dismemberments.

As a new hire, you are allowed a one-time opportunity to elect Voluntary Life coverage up to the guarantee issue amount (if you choose to do so) without having to complete an evidence of insurability (EOI). If you decline coverage at initial offering, you must complete EOI for any coverage amount thereafter. If you elect coverage at initial offering and later wish to increase coverage, you must complete EOI for any increase greater than one increment ($10,000) or for amounts above the guarantee issue amount.

Survivor Benefits

VOLUNTARY LIFE INSURANCE			
RATES/$1,000 (MONTHLY)			
AGE (AS OF JANUARY 1, 2026)	EMPLOYEE	AGE (AS OF JANUARY 1, 2026)	SPOUSE**
Under Age 20	$0.035	Under Age 20	$0.035
Age 20-24	$0.035	Age 20-24	$0.035
Age 25-29	$0.035	Age 25-29	$0.035
Age 30-34	$0.044	Age 30-34	$0.044
Age 35-39	$0.063	Age 35-39	$0.063
Age 40-44	$0.092	Age 40-44	$0.092
Age 45-49	$.0145	Age 45-49	$0.145
Age 50-54	$.0235	Age 50-54	$0.235
Age 55-59	$.0391	Age 55-59	$0.391
Age 60-64	$0.626	Age 60-64	$0.626
Age 65-69*	$1.17	Age 65-69*	$1.17
Age 70+*	$2.46	Age 70+*	$2.46

*Benefits Subject to Age Reduction Schedule
**Spouse rate is based on the employee's date of birth. Any change in the applicable age band for spouse coverage becomes effective on the policy anniversary that falls on or after the employee's birthday.

VOLUNTARY AD&D INSURANCE
PREMIUM RATES – $1,000 (MONTHLY)
Employee - $0.018
Spouse - $0.018
Child - $0.043

VOLUNTARY CHILD LIFE INSURANCE
PREMIUM RATES – $1,000 (MONTHLY)
$0.020

TO CALCULATE HOW MUCH YOUR VOLUNTARY LIFE COVERAGE WILL COST:

$	÷ 1,000 =	$	x Age Based Rate =	$
Benefit Elected				Monthly Premium

Income Protection

Maintaining your quality of life counts on your income. Radiology Ltd. offers disability coverage to protect you financially in the event you cannot work as a result of a debilitating injury. A portion of your income is protected until you can return to work or until you reach retirement age.

Basic Long Term Disability (LTD) Insurance

Long Term Disability (LTD) benefits are provided at no cost to you. LTD insurance replaces 60% of your income if you become partially or totally disabled for an extended time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources for details.

MONTHLY MAXIMUM BENEFIT	$10,000
ELIMINATION PERIOD	90 days
MAXIMUM BENEFIT PERIOD	Payments will last for as long as you are disabled or until you reach your Social Security Normal Retirement Age, whichever is sooner.

Voluntary Short Term Disability (STD) Insurance

Short Term Disability (STD) benefits are available for purchase on a voluntary basis. STD insurance replaces 60% of your income if you become partially or totally disabled for a short time. Certain exclusions, along with pre-existing condition limitations, may apply. See your plan documents or Human Resources for details.

WEEKLY MAXIMUM BENEFIT	$1,250
ELIMINATION PERIOD	7 days
MAXIMUM BENEFIT PERIOD	Up to 13 weeks from date of disability

VOLUNTARY DISABILITY INSURANCE	
	COMPOSITE RATE
VOLUNTARY SHORT TERM DISABILITY	$0.40 per $10 of Covered Benefit (WEEKLY)

TO CALCULATE HOW MUCH YOUR STD COVERAGE WILL COST:

$	÷ 52 =	$	x 60%	$	x Rate	$	÷ $10	$			
Annual Salary		Weekly Income		Weekly Benefit		Amount		Monthly Premium			

Thoughts & Tips: Nearly 6% percent of working Americans will experience a short term disability due to illness, injury or pregnancy on average every year.

Employee Assistance Program

Life can be complicated. With MYgroup, getting help is easy. Your EAP is here to help with life's many challenges. MYgroup provides the following services, paid for by Radiology Ltd.

We know life is complicated, and sometimes we all just need a little help. Our Employee Assistance Program (EAP), through McLaughlin Young helps manage your and your family's total health, including mental, emotional and physical. And it comes at no cost to you.

Through this program, you have access to mental health assistance and legal and financial help from a number of professionals. You and members of your immediate family have 24 hour access to helpful resources by phone and by going online. The EAP benefit also includes three free face-to-face visits per issue with a licensed professional. All services provided are confidential and will not be shared with Radiology Ltd.

You may access information, benefits, educational materials and more either by phone at 800-633-3353 or online at www.mygroup.com.

The Program provides referrals to help with:

- Emotional Health and Wellbeing
- Alcohol or Drug Dependency
- Marriage or Family Relationship Problems
- Job Pressures
- Stress, Anxiety, Depression
- Grief and Loss
- Financial or Legal Advice

Website Access Instructions:

1. Visit www.mygroup.com
2. Select the "Work-Life" Portal
3. Enter Credentials

Username: lumexa

Password: guest

Glossary

Balance Billing – When you are billed by a provider for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $60, you may be billed by the provider for the remaining $40.

Coinsurance – Your share of the cost of a covered healthcare service, calculated as a percent of the allowed amount for the service, typically after you meet your deductible.

Copay – The fixed amount, as determined by your insurance plan, you pay for healthcare services received.

Deductible – The amount you owe for healthcare services before your health insurance begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've paid $1,000 for covered services. This deductible may not apply to all services, including preventive care.

Explanation of Benefits (EOB) – A statement from your insurance carrier that explains which services were provided, their cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision.

Flexible Spending Accounts (FSAs) – A special tax-free account you put money into that you use to pay for certain out-of-pocket healthcare costs. You'll save an amount equal to the taxes you would have paid on the money you set aside. FSAs are "use it or lose it," meaning that funds not used by the end of the plan year will be lost. Some Healthcare FSAs do allow for a grace period or a rollover into the next plan year.

- **Healthcare FSA** – A pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan. All expenses must be qualified as defined in Section 213(d) of the Internal Revenue Code.
- **Limited Use FSA** – Designed to complement a Health Savings Account, a Limited Use FSA allows for reimbursement of eligible dental and vision expenses.
- **Dependent Care FSA** – A pre-tax benefit account used to pay for dependent care services. For additional information on eligible expenses, refer to Publication 503 on the IRS website.

Health Savings Account (HSA) – A personal healthcare bank account funded by your or your employer's tax-free dollars to pay for qualified medical expenses. You must be enrolled in an HDHP to open an HSA. Funds contributed to an HSA roll over from year to year and the account is portable, so if you change jobs your account goes with you.

High Deductible Health Plan (HDHP) – A plan option that provides choice, flexibility and control when it comes to healthcare spending. Most preventive care is covered at 100% with in-network providers, there are no copays and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

Network – A group of physicians, hospitals and other healthcare providers that have agreed to provide medical services to a health insurance plan's members at discounted costs.

- **In-Network** – Providers that contract with your insurance company to provide healthcare services at the negotiated carrier discounted rates.
- **Out-of-Network** – Providers that are not contracted with your insurance company. If you choose an out-of-network provider, services will not be covered at the in-network negotiated carrier discounted rates.

Open Enrollment – The period set by the employer during which employees and dependents may enroll for coverage, make changes or decline coverage.

Out-of-Pocket Maximum – The most you pay during a policy period (usually a 12-month period) before your health insurance begins to pay 100% of the allowed amount. This does not include your premium, charges beyond the Reasonable & Customary, or healthcare your plan doesn't cover. Check with your carrier to confirm what applies to the maximum.

Over-the-Counter (OTC) Medications – Medications available without a prescription.

Prescription Medications – Medications prescribed by a doctor. Cost of these medications is determined by their assigned tier: generic, preferred, non-preferred or specialty.

- **Generic Drugs** – Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding preferred or non-preferred versions. Usually the most cost-effective version of any medication.
- **Preferred Drugs** – Brand-name drugs on your provider's approved list (available online).
- **Non-Preferred Drugs** – Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.
- **Specialty Drugs** – Prescription medications used to treat complex, chronic and often costly conditions. Because of the high cost, many insurers require that specific criteria be met before a drug is covered.
- **Prior Authorization** – A requirement that your physician obtain approval from your health insurance plan to prescribe a specific medication for you.
- **Step Therapy** – The goal of a Step Therapy Program is to steer employees to less expensive, yet equally effective, medications while keeping member and physician disruption to a minimum. You must typically try a generic or preferred-brand medication before "stepping up" to a non-preferred brand.

Reasonable and Customary Allowance (R&C) – Also known as the UCR (Usual, Customary, and Reasonable) amount. 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 R&C amount is sometimes used to determine the allowed amount.

Summary of Benefits and Coverage (SBC) – Mandated by healthcare reform, your insurance carrier provides you with a summary of your benefits and plan coverage.

Summary Plan Description (SPD) - The document(s) that outline the rights, obligations, and material provisions of the plan(s) to all participants and their beneficiaries.

Required Notices

Important Notice From Radiology Ltd. About Your Prescription Drug Coverage and Medicare Under the CIGNA Gold, Silver, and Bronze Plan(s)

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

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

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Radiology Ltd. coverage may not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed herein.

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

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Radiology Ltd. 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 at the end of these notices 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 Radiology Ltd. changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 1, 2026
Name of Entity/Sender:	Radiology Ltd.
Contact—Position/Office:	Human Resources
Address:	677 N. Wilmot Rd Tuscon, AZ 85711
Phone Number:	520-901-6693

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. For deductibles and coinsurance information applicable to the plan in which you enroll, please refer to the summary plan description. If you would like more information on WHCRA benefits, please contact Human Resources at 520-901-6693.

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 deals with how an employer can enforce eligibility and enrollment for healthcare benefits, as well as ensuring that protected health information which identifies you is kept private. You have the right to inspect and copy protected health information that is maintained by and for the plan for enrollment, payment, claims and case management. If you feel that protected health information about you is incorrect or incomplete, you may ask your benefits administrator to amend the information. For a full copy of the Notice of Privacy Practices, describing how protected health information about you may be used and disclosed and how you can get access to the information, contact Human Resources at 520-901-6693.

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e. legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 days after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within 60 days of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within 60 days after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources at 520-901-6693.

Important Contacts

MEDICAL
Cigna
800-244-6224
www.mycigna.com

TELEMEDICINE
MDLive
888-726-3171
myCigna.com

VIRTUAL VISITS
MDLive
myCigna.com

DENTAL
Cigna
800-244-6224
www.mycigna.com

VISION
Cigna
800-244-6224
www.mycigna.com

HEALTH SAVINGS ACCOUNT
HSA Bank
800-357-6246
www.hsabank.com

FLEXIBLE SPENDING ACCOUNTS
HealthEquity
877-924-3967
www.healthequity.com

LIFE AND AD&D
New York Life (formerly Cigna)
888-842-4462
www.mycigna.com

DISABILITY
New York Life (formerly Cigna)
888-842-4462
www.mycigna.com

EAP
MYgroup
800-333-3353
www.mygroup.com
Username: lumexa
Password: guest

RADIOLOGY LTD. HUMAN RESOURCES
677 N. Wilmot Road
Tucson, AZ 85711
520-901-6693

Notes

Radiology Ltd.