fingerpaint

PLAN YEAR

2026 – 2027

Perks *Overview*

Everything we offer to the people who make Fingerpaint, Fingerpaint.

FOR THE FINGERPAINT FAMILY

FULL DETAILS ON HUE

OUR BENEFIT OFFERINGS

Care for you, *and* the people you call family.

Three core plans, picked so the people you love don't get lost in the fine print. All benefits-eligible employees (30+ hrs/wk) can enroll.

HEALTHCARE 01

Healthcare Coverage

All benefits-eligible employees can enroll in individual or dependent medical plans through Fingerpaint. We offer three medical plans through Cigna, each including prescription drug coverage.

CIGNA · 3 PLAN OPTIONS

DENTAL & VISION 02

Dental & Vision Coverage

Two dental plan options through Cigna, plus the Blue View vision plan through Anthem — covering routine eye exams and a portion of the cost of glasses or contacts.

CIGNA · ANTHEM

FAMILY CARE 03

Family Care Benefits

Fourteen weeks of paid parental leave for birth, adoption, or fostering. Up to six weeks of paid caregiver leave for employees caring for a seriously ill family member.

14 WKS PARENTAL · 6 WKS CAREGIVER

OUR FLEXIBLE TIME OFFERINGS

Time to rest. Time to *recharge.*

People first — that's the philosophy. Our time policies are built on mutual trust between Fingerpaint and you.

FLEX PTO 01

Flexible Time Off

Take the time you need. We anticipate employees in good standing will take between 15 and 20 Flex PTO days each year, in addition to company holidays.

15 – 20 DAYS EXPECTED

FLOATING HOLIDAY 02

Identity Day

A floating holiday for you to recognize a day of cultural significance or a religious holiday that isn't reflected in our broader holiday calendar.

ONE FLOATING DAY · PER YEAR

HYBRID WORK 03

Hybrid Work Policy

We're pleased to continue providing a hybrid approach to work that allows our people to work remotely some of the time, dependent on role. Full policy on HUE.

ROLE-DEPENDENT · HYBRID

SICK TIME 04

Paid Sick Time

56 hours per calendar year, prorated based on hire date. Take the time you need to rest, recover, and come back ready.

56 HRS · PRORATED

OUR LEARNING & GROWTH OFFERINGS

Keep *growing.* On us.

Programs that invest in where you're going next — professionally and personally.

ANNUAL BUDGET

01

External Learning Program

Fingerpaint is dedicated to the learning and development of our employees by offering individual financial assistance for external professional development opportunities yearly. More information lives on HUE.

ANNUAL · PER EMPLOYEE

CAREER FRAMEWORK

02

Opportunities for Growth

Career Framework Guides help you map your path within your department and the broader Fingerpaint organization. An annual review process ensures each employee is formally reviewed each year.

ANNUAL REVIEW · CAREER GUIDES

OUR WELLNESS OFFERINGS

Look after *yourself.* We'll back you up.

Real support for everyday wellness — flexible dollars to spend on what matters to you, and confidential help when you need someone to talk to.

01

LIFESTYLE SPENDING ACCOUNT

LSA · $150 for 2026

Fingerpaint provides a Lifestyle Spending Account giving you dollars each year to spend on the things that support your well-being — fitness, stress reduction, or other wellness activities important to you. Access your LSA through Employee Benefits Corporation.

$150 / YEAR · EBC

02

EAP

Employee Assistance Program

The EAP is designed to help you lead a happier, more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor who can help with stress, anxiety, relationship issues, grief, job stress, parenting, and more.

UNUM · CONFIDENTIAL · FREE

OUR RECOGNITION TOOLS

Shout it from the *rooftops.*

Three ways we celebrate each other — for the wins, the everyday moments, and the milestones that matter most.

PEER RECOGNITION

01

HighFive

Our employee recognition platform — shout out colleagues across the company for a job well done. Shout-outs tie back to our values: grow, people first, challenge, and inspire.

SLACK · TEAMS · WEB

ABOVE & BEYOND

02

Spot Awards

For highlighting those who've gone above and beyond — typically presented during town halls. Given as HighFive points redeemable for swag, gift cards, Amazon items, or charity.

HIGHFIVE POINTS · REDEEMABLE

LIFE MOMENTS

03

Life Events Program

Being part of the Fingerpaint Family means we're alongside you for celebrations — new pet, new baby, marriage, new home — and we'll support you during the tough times, too.

CELEBRATIONS · IN MEMORIAM

OUR FINANCIAL WELLNESS OFFERINGS

Money in the bank, *and* off the books.

Three programs that help you save now and plan for what's next — including a new way to stretch your monthly budget.

SINCE 2018 · 01

Student Loan Repayment

Established April 2018, Fingerpaint's student loan repayment program through Gradifi is available to all employees with student loan debt. Each enrolled employee receives $120 a month toward their loan.

GRADIFI · $120 / MO

RETIREMENT · 02

401(k)

All full-time, part-time, and temporary employees are eligible to participate in the 401(k) plan through Principal. Eligible employees are automatically enrolled at 5%.

PRINCIPAL · AUTO-ENROLL AT 5%

VOLUNTARY · EMPLOYEE-PAID · NEW

Previ

Save on mobile plans, home/auto insurance, and device protection. Zero cost to the employer — a $99/yr employee enrollment fee unlocks an average of $1,259/yr in mobile savings and $1,551/yr in insurance savings.

$99 / YR · T-MOBILE & AT&T

ADDITIONAL OFFERINGS

A few *more* to round it out.

Voluntary protection, legal advice, and — new this year — a pet wellness benefit for the four-legged members of your family.

VOLUNTARY BENEFITS

01

Cigna Voluntary Benefits

Fingerpaint offers critical illness, accident, and hospital options through Cigna. Enroll in these voluntary benefits during open enrollment.

CRITICAL ILLNESS · ACCIDENT · HOSPITAL

LEGAL ADVICE

02

Legal Club

Legal Club provides legal advice, services, and counseling at a free or discounted rate — writing a will, preparing taxes, resolving a traffic violation, and much more.

FREE & DISCOUNTED SERVICES

PET WELLNESS · VOLUNTARY

NEW

Wagmo

Routine and preventative care for cats and dogs — exams, blood work, vaccinations, preventative medications, and grooming. Three tiers (Value, Classic, Deluxe), starting at $23/mo for one pet. Up to 5 pets per employee.

FROM $23 / MO · POST-TAX

fingerpaint GROUP

BENEFITS GUIDE

2026 – 2027







Your Fingerpaint Group Benefits

We understand the important role that benefits play in our lives and in our overall health. That's why we provide a benefits package that lets you elect the right coverage for you and your family, as a new hire and each year during Annual Enrollment.

This benefits guide can help to familiarize you with your options in Fingerpaint Group's benefits program. It also provides useful tips, tools and resources to help you think through your options and make wise decisions.

Getting ready to enroll:

- Consider your coverage needs for the upcoming year. For example, do you want to be financially protected if you can't work due to an accident or illness?
- Consider other available coverage.
- Gather information you'll need. If you're covering dependents, you'll need their dates of birth and Social Security numbers.

Getting the most value from your benefits depends on how well you understand your plans and how you choose to use them. Be sure to read this entire guide for important information about your benefit options.

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Enrolling in your benefits

- Create an account or log in with your existing account at https://workforcenow.adp.com
- Begin the benefits enrollment process
- Elect the benefits you want
- Save or submit your elections
- Print a copy of your elections for your records

Benefit Basics

Your benefits are a partnership between you and Fingerpaint Group. The table below outlines how you and Fingerpaint Group share costs for benefits. The tax treatment shows whether your contribution is taken from your paycheck before or after taxes.

Benefit	Tax Treatment	Who Pays
Medical and Pharmacy	Pretax	Fingerpaint Group & You
Dental	Pretax	You
Vision	Pretax	You
Health Savings Account	Pretax	Fingerpaint Group & You
Flexible Spending Accounts	Pretax	You
Lifestyle Spending Account (LSA)	After-tax	Fingerpaint Group
Basic Life and Accidental Death & Dismemberment (AD&D) Insurance	After-tax	Fingerpaint Group
Voluntary Life and AD&D Insurance	After-tax	You
Core Short-Term Disability*	After-tax	Fingerpaint Group
Buy-Up Short-Term Disability	After-tax	You
Long-Term Disability	After-tax	You
Accident Insurance	After-tax	You
Cancer/Specified Illness Insurance	After-tax	You
Hospital Indemnity Insurance	After-tax	You
Pet Insurance	After-tax	You
Legal Plan	After-tax	You
Student Loan Paydown Program	After-tax	Fingerpaint Group
401(k) Retirement Savings Plan	Pretax or After-tax	Fingerpaint Group & You

*Not available for employees working in New Jersey or California.



Eligibility

Who's eligible?

Employees

Employees who work at least 30 hours per week are eligible for the benefits described in this guide. Most benefits are effective on your date of hire.

Dependents

- Your legal spouse
- Your domestic partner
- Your children up to age 26

Changing your benefits

Generally, you may only make or change your benefit elections as a new hire or during the Annual Enrollment period. However, you may change your benefit elections during the year if you experience a qualifying event such as:

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

You have 30 days from the qualified life event to make changes to your coverage.

- Depending on the type of event, you may need to provide proof of the event, such as a marriage license.
- If you do not make the changes within 30 days of the qualified event, you will have to wait until the next Annual Enrollment period to make changes (unless you experience another qualified life event).

Enrolling dependents? Items to have ready

When you add dependents to your coverage, you must provide their:

- Legal name
- Date of birth
- Social Security number
- Supporting documentation, such as marriage certificate, birth certificate, adoption papers, and tax documents.

If you do not provide the required information, your dependents may be dropped from coverage.

Medical and Pharmacy Plan Overview

We offer the choice of three medical plans through Cigna. All of the medical options include coverage for prescription drugs. To select the plan that best suits your family, consider the key differences between the plans, the cost of coverage (including payroll deductions) and how the plan covers services throughout the year.

Understanding how your plan works

1. Your deductible

You pay out-of-pocket for most medical and pharmacy expenses, until you reach the deductible. If you are enrolled in the EPO with HSA Plan, you can pay for these expenses from your Health Savings Account (HSA).

2. Your coverage

Once your deductible is met, you and the plan share the cost of covered medical and pharmacy expenses with coinsurance. The plan will pay a percentage of each eligible expense, and you will pay the rest.

3. Your out-of-pocket maximum

When you reach your out-of-pocket maximum, the plan pays 100% of covered medical and pharmacy expenses for the rest of the plan year. Your deductible and coinsurance apply toward the out-of-pocket maximum.

The difference between aggregate and embedded deductibles and out-of-pocket maximums

- **With an aggregate approach,** there is one family limit that applies to everyone. When one or a combination of family members has met the limit (family deductible or out-of-pocket maximum), it is met for all of you. Then, the plan will begin paying its share of eligible expenses for the whole family for the rest of the year.
- **With an embedded approach,** each person only needs to meet the individual deductible and out-of-pocket maximum before the plan begins paying its share for that individual. (And, once two or more family members meet the family limits, the plan begins paying its share for all covered family members).
- **All three (3) Medical Plans are administered using the embedded approach.**

Making the most of your plan

Getting the most out of your plan also depends on how well you understand it. Keep these important tips in mind when you use your plan.

- **In-network providers and pharmacies:** You will always pay less if you see a provider within the medical and pharmacy network.
- **Preventive care:** In-network preventive care is covered at 100% (no cost to you). Preventive care is often received during an annual physical exam and includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms.

Understanding your pharmacy coverage

- **Preventive drugs:** Many preventive drugs and those used to treat chronic conditions like diabetes, high blood pressure, high cholesterol and asthma are on the Preventive Condition Drug List. These prescriptions are covered at 100% (no cost to you) when you use an in-network pharmacy.
- **Mail order pharmacy:** If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can use the Mail Order Pharmacy to save on a 90-day supply.
- **Prescription categories:** Medications are placed in categories based on drug cost, safety and effectiveness. These tiers also affect your coverage.
  - **Generic** – A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.
  - **Brand preferred** – A drug with a patent and trademark name that is considered “preferred” because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.
  - **Brand non-preferred** – A drug with a patent and trademark name. This type of drug is “not preferred” and is usually more expensive than alternative generic and brand preferred drugs.

Medical and Pharmacy Coverage

Medical Plan Provisions	PPO		EPO	EPO with HSA
	In-Network	Out-of-Network	In-Network	In-Network
Fingerpaint Group Contribution to HSA (Individual/Family)	N/A		N/A	$250/$500
Annual Deductible (Individual/Family)	$750/$1,500	$2,000/$4,000	$2,000/$4,000	$3,500/$7,000
Out-of-Pocket Maximum (Includes Deductible)	$6,500/$13,000	$6,500/$13,000	$5,000/$10,000	$4,500/$9,000
Preventive Care	Covered at 100%	30%*	Covered at 100%	Covered at 100%
Primary Care Provider Office Visit	$30 copay	30%*	$35 copay	30%*
Specialist Office Visit	$50 copay	30%*	$60 copay	30%*
X-Ray and Lab	20%*	40%*	30%*	30%*
Inpatient Hospital Services	20%*	40%*	30%*	30%*
Outpatient Hospital Services	20%*	40%*	30%*	30%*
Urgent Care	$40 copay	$40 copay	$50 copay	30%*
Emergency Room	$200 copay		$200 copay	30%*
Pharmacy Provisions				
Prescription Drug Deductible (Individual/Family)	Not applicable	Not covered	$100/$200 deductible on Tier 2 and Tier 3	Combined with medical
Retail Pharmacy (up to a 30-day supply)				
Generic	$10 copay	Not covered	$10 copay	$10*
Brand Preferred	$50 copay	Not covered	$50 copay	$50*
Brand Non-Preferred	$70 copay	Not covered	$70 copay	$70*

*After deductible

Your bi-weekly payroll contributions for medical benefits are shown here.

Coverage Level	PPO	EPO	EPO with HSA
Employee Only	$218.37	$148.34	$57.41
Two Person	$420.82	$287.77	$115.96
Family	$651.35	$451.79	$184.43

Medical Plan Resources

Cigna Health Information Line

- Call 1-800-Cigna24 to speak with a registered nurse 24/7.
- The nurses can help you decide whether you or a family member should go to the emergency room or urgent care center or make a doctor's appointment.

Virtual Care

- Cigna is a 24/7 service that provides access to board-certified doctors by mobile app, online video or phone.
- Whether you're at home, at work, traveling or you simply want a more convenient way to see a doctor, telemedicine is easy to use and available anytime, anywhere.
- Get care for allergies, asthma, colds, flu, ear aches, pinkeye, rashes and more. You can even get a prescription, if needed.
- Cigna has a full mental health network from providers such as MDLive, Talkspace and Headspace to support emotional, behavioral and social needs. You and your covered dependents can visit with a licensed counselor, therapist or psychologist from the comfort of your home through phone calls or video chats. Actual costs may vary depending on plan type, provider type, length of session, diagnosis and type of service. Program services are provided by independent companies/entities and not by Cigna. Program availability is subject to change.
- Sign up at myCigna.com or download the myCigna® app.

Diabetes management

- Omada is a program designed to help you avoid the onset of diabetes and the health risks that might lead to heart disease or a stroke.
- For more information, visit myCigna.com or the Cigna mobile app.

Healthy Babies/Healthy Pregnancies

- When you enroll in Cigna Healthy Pregnancies, Healthy Babies and complete the program, including your postpartum check-in, you'll be eligible to receive a reward of $150 if you enroll during the first trimester or $75 in second trimester.
- For more information, visit myCigna.com or the Cigna mobile app.

Decision Support Tool

HYKE

Choosing your health plan just got easier

Choosing your benefits can be difficult, but Hyke (formerly Decision Doc) makes it easy! Use the free, confidential, and secure platform to receive a personalized protection score and guidance on how to improve your overall financial wellness through the benefits available to you.

Answer questions

Scan or click your unique HYKE link and answer a series of questions about healthcare needs, finances and family.

Get your Score

Your Protection Score measures your health and financial needs, and tells you which benefits will help you stay protected. Edit responses to see how different needs may change your score.

Save your guide

Save or print your score dashboard and use the information to make an informed enrollment decision.

If you have questions, reach out to questions@letshyke.com.

Employees using HYKE will be able to decide what plan best fits your needs based on answering questions.



Savings and Spending Accounts



Fingerpaint Group offers several accounts that enable you to pay for eligible expenses tax-free. The IRS provides a list of eligible expenses for each account at www.irs.gov.

Health Savings Account (HSA)	Health Care Flexible Spending Accounts (FSAs)	Dependent Care FSA
Available to those enrolled in the EPO with HSA as long as you are not enrolled in any other health coverage or Medicare or claimed as a dependent on someone else's tax return.	Your options depend on your medical plan enrollment. • **Health Care FSA** – If you are not enrolled in the EPO with HSA, you can use this account for medical, pharmacy, dental and vision expenses. • **Limited Purpose FSA** – If you are enrolled in the EPO with HSA, you can use this account to pay for dental and vision expenses only.	Use for eligible childcare expenses for dependents under age 13 or elder care.

Comparison of accounts

	HSA	FSA
Does the company contribute? *Amount for full-year 2026*	✓ Employee: $250 Employee +1 or Family: $500	×
Can I contribute my own savings?	✓	✓
Is there an IRS maximum annual contribution?	✓ Employee: $4,400 Family: $8,750 Those 55 and older can contribute an additional $1,000 annually.	✓ Health Care or Limited Purpose FSAs: $3,400 Dependent Care FSA: $5,000
Will my savings roll over each year?	✓ Unlimited	! Up to $660 for Health Care and Limited Purpose FSAs; No roll over for Dependent Care FSA
Will I earn interest on my savings?	✓	×
Are the savings tax-free? *In most states*	✓	✓
Do I keep the money if I leave the company?	✓	×
Can I also have a Flexible Spending Account (FSA)?	! Limited Purpose and Dependent Care FSAs only	N/A

Lifestyle Spending Account (LSA)

The LSA is available to all benefit eligible employees and is a flexible benefit designed to support your overall wellbeing. The LSA provides reimbursement for a wide range of eligible expenses that promote physical, mental, and financial wellness. These expenses can include things like gym memberships, childcare, mental health services, and other wellness-related items.

Fingerpaint Group will reimburse up to $150 for the calendar year (January 1, 2026 through December 31, 2026).

Health Savings Account

A Health Savings Account (HSA) is a savings account that belongs to you that is paired with the EPO with HSA. It allows you to make tax-free contributions that you can use to pay for current and future medical expenses for you and your dependents.

Start It

- Contributions to an HSA are tax-free for you – whether they come from you or the company. The company contributes $250 for individual coverage and $500 for family coverage (see below).
- The HDHP costs less than other plans so the money you save on premiums can be put into your HSA. This helps you save money on taxes and gives you more flexibility and control over your health care dollars.

Build It

- All of the money in your HSA is yours (including any contributions deposited by the company) even if you leave your job, change plans or retire.
- In 2026, the total of your contributions and the company's can be up to $4,400 for individual coverage and $8,750 for family coverage. If you are age 55 or older, you can contribute an additional $1,000 per year.

Use It

- You can withdraw your money tax-free at any time, as long as you use it for qualified expenses (a list can be found on www.irs.gov).
- You can also save this money and hold onto it for future eligible health care expenses.

Grow It

- Unused money in your HSA will roll over, earn interest and grow tax-free over time.
- You decide how to use the HSA money, including whether to save it or spend it for eligible expenses. When your balance is large enough, you can invest it – tax-free.

Eligibility details

- You cannot have an HSA if you are enrolled in any other health coverage or Medicare, or claimed a dependent on someone else's tax return.
- You cannot participate in the Health Care Flexible Spending Account (FSA) if you have an HSA. Your spouse/domestic partner also cannot have a Health Care FSA.

Employer contribution detail

- You are eligible for the full employer contribution to your Health Savings Account (HSA) if you are actively employed on January 1, 2027, and have opened an HSA through Bank of America. The contribution will be made as part of regular company payroll process in January 2027.
- If your start date in the plan is after January 1, 2027, you are eligible for the full employer contribution to your Health Savings Account (HSA) if you are actively employed on June 1, 2027, and have opened an HSA through Bank of America. The contribution will be made as part of regular company payroll process in June 2027.

Flexible Spending Accounts

A Flexible Spending Account (FSA) helps you pay for health or dependent care costs using tax-free dollars. Your contribution is deducted from your paycheck on a pretax basis and put into the FSA. When you incur expenses, you can access the funds in your account to pay for *eligible* expenses.

This chart shows the eligible expenses for each type of FSA and how much you can contribute per year. Each of these options reduces your taxable income.

Account type	Eligible expenses	Annual contribution limits
Health Care FSA	Most medical, dental and vision care expenses that are not covered by your health plan, such as copays, coinsurance, deductibles, eyeglasses, orthodontia and prescriptions.	Maximum contribution is $3,400 per year. You cannot enroll if you are enrolled in the EPO with HSA plan. Funds are deducted throughout the year, but all funds are available on July 1.
Limited Purpose FSA	Only dental and vision expenses that are not covered by your medical, dental or vision plans, such as copays, coinsurance, deductibles, eyeglasses and orthodontia.	Maximum contribution is $3,400 per year. This is available to those enrolled in the EPO with HSA plan. Funds are deducted throughout the year, but all funds are available on July 1.
Dependent Care FSA	Dependent care expenses including day care, after school programs for children under age 13 or elder care programs so you can work or attend school full-time.	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns).

Important information about FSAs

- Your FSA elections are effective from July 1 through June 30.
- Claims for reimbursement must be submitted by September 30 of the following year.
- The Health Care or Limited Purpose FSAs allow you to carry over $660 in unused funds to the following plan year.
- The Dependent Care FSA offers a grace period which affords participants an additional 2.5 months after the plan year ends to incur eligible expenses.
- Please plan your contributions carefully. Any unused money remaining in your account(s) will be forfeited. This is known as the “use it or lose it” rule and it is governed by Internal Revenue Service regulations.
- FSA elections do not automatically continue from year to year; you must actively enroll each year.
- You can only change your FSA contribution amount if you experience a qualified status change.
- The FSA plans are not interchangeable. You must enroll in each separately and funds are non-transferable.

Dental Plan



It's important to have regular dental exams and cleanings so problems are detected before they become painful – and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and is an important part of maintaining your overall health. We offer two dental plans through Cigna.

Plan Provisions	High PPO Dental Plan		Low PPO Dental Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible (Individual/Family)	$50/$150	$50/$150	$100/$300	$100/$300
Calendar Year Maximum (per Individual)	$1,250	$1,250	$1,000	$1,000
Diagnostic and Preventive Services (e.g., X-rays, cleanings, exams)	Covered at 100%	Covered at 100%	Covered at 100%	10%
Basic and Restorative Services (e.g., fillings)	10%	20%	10%	30%
Major Services (e.g., dentures, crowns, bridges)	40%	50%	40%	50%
Orthodontia (children up to age 19)	50%, up to a lifetime maximum of $2,000 per individual		50%, up to a lifetime maximum of $2,000 per individual	

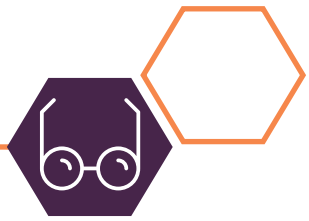
Your bi-weekly payroll contributions for dental benefits are shown here.

Coverage Level	High PPO Dental Plan	Low PPO Dental Plan
Employee Only	$18.29	$17.19
Two Person	$61.26	$57.59
Family	$61.26	$57.59

Get the most from your dental plans

- **Stay in-network** – While you have the option of choosing any provider, you save money when you use in-network dentists. When using an out-of-network dental provider, you pay more because the provider has not agreed to charge you a negotiated rate.
- **Free annual check-up** – Use free preventive care to keep your mouth and gums healthy all year long.
- **Use your FSA or HSA funds** – Help pay for eligible out-of-pocket dental expenses.

Vision Plan



The vision plan provides coverage for routine eye exams and pays for all or a portion of the cost of glasses or contact lenses. You can choose any provider; however, you always save money if you see in-network providers. We offer a vision plan through Anthem Blue Vision.

Plan Provisions	Anthem Blue Vision	
	In-Network	Out-of-Network
Exam	$20 copay	Up to $42 allowance
Frames	$150 allowance plus 20% off balance	Up to $45 allowance
Lenses		
• Single vision	$20 copay	Up to $40 allowance
• Bifocal	$20 copay	Up to $60 allowance
• Trifocal	$20 copay	Up to $80 allowance
Contact Lenses		
• Elective (in lieu of glasses)	$150 allowance, then 15% off balance	Up to $105 allowance
• Medically necessary	Covered at 100%	Up to $210 allowance
Frequency		
• Exam	Once every calendar year	
• Lenses	Once every calendar year	
• Frames	Once every calendar year	
• Contact lenses	Once every calendar year	

Your bi-weekly payroll contributions for vision benefits are shown here.

Coverage Level	Anthem Blue Vision
Employee Only	$2.22
Two Person	$4.22
Family	$6.47

Pay for vision expenses tax-free

Use your **FSA or HSA** to pay for your exam copay and eyeglasses or contacts.

Life Insurance

Life and AD&D insurance

Fingerpaint Group provides basic life and AD&D insurance for employees and offers voluntary insurance options for employees and their dependents through Unum.

Basic life and AD&D insurance

- Life insurance is an important part of your financial wellbeing, especially if others depend on you for support.
- Fingerpaint Group provides basic life and accidental death and dismemberment insurance through Unum to all eligible employees at **no cost** equal to $50,000.
- Coverage is automatic; you do not need to enroll.

Voluntary life and AD&D insurance

- You may choose to purchase additional life and AD&D coverage through Unum for yourself and your dependents at affordable group rates.
- Rates are based on age and the coverage level chosen.

Voluntary life and AD&D insurance for you

Employee

- Increments of $10,000 to a maximum of $500,000 or five times your salary
- Guaranteed issue up to $150,000 for newly eligible employees

Voluntary life and AD&D insurance for your dependents

Spouse/Domestic Partner

- Increments of $5,000 to $250,000 (not to exceed 100% of your voluntary life and AD&D coverage)
- Guaranteed issue up to $50,000 for newly eligible employees

Child(ren)

- Increments of $5,000 up to $10,000 (not to exceed 50% of your voluntary life and AD&D coverage)
- Covered from age 15 days
- Must be added within 31 days of birth

If you would like to enroll in voluntary life insurance and are not first eligible, you are required to complete a health statement and submit it to Unum for approval.

Your monthly payroll contributions for voluntary life and AD&D insurance are shown below.

Monthly Cost per $1,000 of Coverage

Age Band	Rate per $1000
Under 25	$0.031
25-29	$0.026
30-34	$0.034
35-39	$0.054
40-44	$0.089
45-49	$0.143
50-54	$0.230
55-59	$0.371
60-64	$0.546
65-69	$0.917
70-74	$2.030
75+	$2.060

Per Child Unit: $0.207 Per $1,000

AD&D insurance: $0.02 Per $1,000

Protect your loved ones

- **Affordable supplemental coverage** – Take advantage of the group rates offered to get the best deal on your coverage. Investing in insurance give you peace of mind and the financial protection for yourself and your loved ones.
- **Be sure to designate your beneficiary** – You must choose a beneficiary for life and AD&D insurance. Keep your beneficiaries up-to-date in ADP Workforce Now.

Disability Insurance



Disability insurance through Unum provides income replacement should you become disabled and unable to work due to a non-work-related illness or injury. Fingerpaint Group offers a company paid short-term disability (STD) plan (for employees outside of New Jersey and California), a voluntary buy-up STD plan and a voluntary long-Term disability (LTD) plan. The buy-up STD benefit would be offset by the Core plan and all state mandated benefits.

Coverage	Benefit
Core Short-Term Disability (Company Paid)	60% of weekly earnings up to $500 per week for up to 24 weeks. There is a 14-day waiting period. All full-time employees are eligible except for those working in NJ and CA are eligible. The $500 Core benefit will be offset by any benefits received under states where there is a mandated disability plan.
Buy-Up Short-Term Disability (Employee Paid)	60% of weekly earnings up to $2,500 weekly benefit (includes the $500 Core plan paid for by the company if you are eligible). State mandated disability benefits in New York, New Jersey and California (and any other state) will be an offset. The maximum weekly benefit is $2,500 from all sources. Preexisting condition limitations will apply. If you were treated for a condition 3 months before the effective date of the plan, you will not be covered for the condition for 12 months.
Long-Term Disability (Employee Paid)	60% of your monthly salary to a maximum monthly benefit of $15,000. You must be certified disabled and unable to work for more than 180 days (waiting period) by Unum. Benefits are offset with income from Social Security, Workers' Compensation, etc. Preexisting condition limitations will apply.

Voluntary Long Term Disability Monthly Rates

Age Band	Rate per $100 Covered Monthly Payroll
Under 25	$0.043
25-29	$0.085
30-34	$0.117
35-39	$0.202
40-44	$0.276
45-49	$0.403
50-54	$0.478
55-59	$0.584
60-64	$0.615
65-69	$0.648
70 and above	$0.679

Buy Up Short Term Disability Monthly Rate

Monthly Rate per $10	**$0.250**

Note: If you would like to enroll in the voluntary STD and/or LTD and are not first eligible, you are required to complete a health statement.

Voluntary Plans

Round out your coverage with benefits that offer financial protection and assistance with all areas of your life.

Accident Insurance (Cigna)

Provides benefits to help cover the costs associated with unexpected bills due to covered accidents, regardless of any other insurance you have.

If you purchase coverage and are hurt in a covered accident, you will receive a cash benefit for covered injuries that you may spend as you like.

Examples of covered injuries:

- Broken bones
- Burns
- Concussions
- Cuts repaired by stitches
- Eye injuries
- Ruptured discs
- Torn ligaments

Please note: Accident insurance benefits for a pre-existing condition will not be paid during the first 12 months the policy is in force.

Hospital Indemnity Insurance (Cigna)

Hospital indemnity insurance provides a fixed lump-sum payment that can help cover hospital expenses not covered by insurance, or to pay for expenses while you, your spouse/domestic partner, and/or dependents are in the hospital.

Legal plan

The legal plan provides legal representation for you, your spouse/domestic partner, and your dependents at a price that won't break your budget. You can receive legal advice and fully covered legal services for a wide range of personal legal matters from a network-participating plan attorney. Services provided through the plan include:

- Court appearances
- Debt collection defense
- Document review and preparation
- Family law
- Real estate matters
- Will preparation

When you use a plan attorney for covered services, there is no waiting period, limits on usage, deductibles or copays. The plan is available at a low monthly group rate, which you can pay through automatic payroll deductions. To access plan benefits, or for questions about your membership, call 800-305-6816.

Cancer/Specified Disease Insurance (Cigna)

Cigna's cancer/specified-disease insurance policies are designed to pay cash benefits that can be used to help offset cancer-related expenses and to help with a variety of daily living expenses. For more information about policy benefits, limitations, and exclusions, please check the ADP site for more details.

This plan is available at a low monthly group rate, which you can pay through automatic payroll deductions.

Pet Wellness Program

Wagmo Wellness provides perks and reimbursements for dog and cat parents, covering routine and preventive care with fast, 24-hour claim reimbursements. Members also enjoy 24/7 access to televet services at no additional cost, along with exclusive savings on products from leading pet brands.

To learn more or request a quote, visit wagmo.io or call 1-855-836-8785.

Previ Discount Program

Previ Benefits provides savings on everyday services, including mobile phone plans, home and auto insurance, and device protection. Members pay a single annual enrollment fee to access multiple savings opportunities at no additional cost.

To learn more or enroll, visit previ.com/benefit/fingerpaint-group or call 801-437-0620.

Additional Benefits

Employee Assistance Program

Life is filled with change and uncertainty. The responsibilities and demands on our time can be overwhelming. Our Employee Assistance Program (EAP) is here to help you and your family members with life's challenges.

The Health Advocate EAP, courtesy of Unum, provides 24/7 confidential support, resources and information for you and your dependents. You and your family have access to three free consultations with a licensed clinician per incident, per individual, per calendar year. Services include:

- **Childcare and eldercare assistance:** Needs assessment along with referrals to childcare and eldercare providers.
- **Daily living services:** Referrals to help with event planning, transportation services, pet services and more.
- **Financial services:** Budgeting, credit and financial guidance, retirement planning and assistance with tax issues.
- **Identity theft recovery services:** Information on identity theft prevention, an identity theft emergency response kit and help if you are victimized.
- **Legal services:** Consultations for issues relating to civil, consumer, personal and family law, financial matters, business law, real estate, estate planning and more.
- **LGBTQ+ resources:** LGBTQ+ friendly therapists, support groups and educational materials for people of all ages.

Health Advocate EAP courtesy of Unum:
Confidential assistance is available any time.
Call 800-854-1446 or visit unum.com/lifebalance.

Health Advocate

- Health Advocate provides confidential, free services 24/7 to all benefits-eligible employees and their families.
- This resource can simplify your health care experience and help you make informed decisions about your care.
- An advocate can also help find health care, schedule appointments, and understand covered services, pre-certification requirements, issues with billing, types of medications, how to save money, what questions to ask your doctor, alternative treatment options, and more.
- To get started, call 866-989-2942 or email answers@HealthAdvocate.com.
  URL: healthadvocate.com/healthadvocacyplus
  Registration Code: WTWHAPLUS

Student Loan Paydown (SLP) program

Fingerpaint Group partners with Gradifi to offer you competitive student loan refinancing options. Features include:

- The SLP plan helps you pay down your student loans by making a direct contribution to your student loan account.
- Fingerpaint Group will send the contribution to Gradifi and we will make the payment directly to your loan servicer.
- We will contribute $120 per month, until your loan is paid off.
- To qualify, you must enter a valid student loan where you are the primary borrower of a federal or private loan from a US-based lender taken out exclusively for funding higher education expenses at an accredited institution.
- You will receive an email from Gradifi with a link to sign up.
- Sign up for an account and enter your student loan information. Gradifi will be notified that you have created your account and will start making payments when your company's plan starts.
- You will not receive a contribution until you register a valid student loan with Gradifi.

401(k) Retirement Savings Plan

Whether retirement is way down the road or just around the corner, it's important to have savings goals and specific investment objectives. To help you meet your goals and objectives, we offer a 401(k) Retirement Savings Plan, administered by Principal, with multiple investment options and a company match.

Employee Contributions	Employer Contributions
• You can contribute up to $24,500 in 2026 (subject to change by the IRS), and if you are age 50 or older, you may contribute up to an additional $7,500 as a "catch-up" contribution. • Contributions may be made on a pretax or Roth after-tax basis.	• Fingerpaint Group will match 100% of the first 3%, plus 50% of the next 2% of the pay you contribute to the plan through salary deferral. • When a matching contribution is made to the plan, it will be calculated based on salary deferrals and pay as of the end of the pay period. • Employer contributions may change in the future.

Eligibility

- All full-time, part-time and temporary employees age 21 or older are eligible to contribute to the 401(k) plan after you receive your first paycheck.
- If no action is taken beforehand, you will be automatically enrolled in the plan after 30 days at a pretax savings rate of 5% of your gross pay.
- Auto-enrolled accounts will be invested in the plan's default investment fund.
- Employees can proactively enroll ahead of the 30-day time period, elect not to participate, make adjustments to your savings rate, and/or redirect investment to another fund (or funds) through the plan administrator.

More information

- You can enroll in the plan and make changes to your contributions at any time.
- Principal has many different investment options for you to choose from, along with tools and resources you can use to determine which options best meet your investment objectives.

For additional details about the 401(k) Retirement Savings Plan or to enroll or change your contribution rates or investment elections, visit www.principal.com/nextsteps or call 800-547-7754.

Vesting

Vesting refers to your ownership of the money in your 401(k).

- You are 100% vested in the company match immediately.
- You are always 100% vested in your contributions to the plan.
- You cannot forfeit these contributions.



Helpful Benefit Terms

- **Brand preferred drugs** – A drug with a patent and trademark name that is considered "preferred" because it's safe and effective and usually less expensive than other brand-name options.
- **Brand non-preferred drugs** – A drug with a patent and trademark name that is "not preferred" because it's usually more expensive than other generic and brand preferred options.
- **Calendar year maximum** – The maximum benefit amount paid each year for each family member enrolled in the dental plan.
- **Coinsurance** – The sharing of cost between you and the plan. For example, 80% coinsurance means the plan covers 80% of the cost of service after a deductible is met. You will be responsible for the remaining 20% of the cost.
- **Copay** – A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of service.
- **Deductible** – The amount you have to pay for covered services each year before your health plan begins to pay.
- **Elimination period** – The time period between the beginning of an injury or illness and receiving benefit payments from the insurer.
- **Evidence of Insurability (EOI)** – EOI is documentation or declaration of good health requested by the insurance company in order for the enrollee to obtain coverage.
- **Flexible Spending Accounts (FSA)** – FSAs allow you to pay for eligible health care and dependent care expenses using tax-free dollars. The money in the account is subject to the "use it or lose it" rule which means you must spend the money in the account before the end of the plan year.
- **Generic drugs** – A drug that is equivalent to brand-name drugs in use, dose, strength, quality and performance, but is not trademarked.
- **Guaranteed issue** – Guaranteed issue refers to coverage that is offered to all eligible enrollees regardless of their health status.
- **Health Savings Account (HSA)** – An HSA is a personal savings account for those enrolled in a High Deductible Health Plan (HDHP). You may use your HSA to pay for qualified medical expenses such as doctor's office visits, hospital care, prescription drugs, dental care and vision care. You can use the money in your HSA to pay for qualified medical expenses now, or in the future, for your expenses and those of your dependents, even if they are not covered by the HDHP.
- **Health Reimbursement Arrangement (HRA)** – A fund you can use to help pay for eligible medical costs not covered by your medical plan. Funds are contributed to the HRA by the company.
- **High Deductible Health Plan (HDHP)** – A qualified High Deductible Health Plan (HDHP) is defined by the Internal Revenue Service (IRS) as a plan with a minimum annual deductible and a maximum out-of-pocket limit. These minimums and maximums are determined annually and are subject to change.
- **In-network** – A designated list of health care providers (doctors, dentists, etc.) with whom the insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the company.
- **Inpatient** – Services provided to an individual during an overnight hospital stay.
- **Mail order pharmacy** – Mail order pharmacies generally provide a 90-day supply of a prescription medication for the same cost as a 60-day supply at a retail pharmacy. Plus, mail order pharmacies offer the convenience of shipping directly to your door.
- **Out-of-network** – Providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of-network providers is much higher for you and the company. Higher deductibles and coinsurance will apply.
- **Out-of-pocket maximum** – The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.
- **Outpatient** – Services provided to an individual at a hospital facility without an overnight hospital stay.
- **Pre-existing condition** – A health condition that an individual was treated for, or got medical advice from a doctor about, prior to when they applied for health or life insurance. This can also apply if a person had existing symptoms that would cause them to seek treatment.
- **Primary Care Provider (PCP)** – A doctor (generally a family or internal medicine practitioner or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.
- **Reasonable & Customary Charges (R&C)** – Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Reasonable and Customary rates may apply to out-of-network charges.
- **Specialist** – A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist or neurologist).
- **Specialty drugs** – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Benefit acronyms

ACA – Affordable Care Act
AD&D – Accidental Death & Dismemberment
FSA – Flexible Spending Account
HDHP – High Deductible Health Plan
HMO – Health Maintenance Organization
HSA – Health Savings Account
LPFSA – Limited Purpose Flexible Spending Account
LTD – Long-Term Disability
PPO – Preferred Provider Organization
STD – Short-Term Disability

Contact Information



Coverage	Carrier	Phone	Website/Email
Medical and Pharmacy	Cigna	800-Cigna-24 (800-244-6224)	www.cigna.com
Dental	Cigna	800-Cigna-24 (800-244-6224)	www.cigna.com
Vision	Anthem	866-723-0515	www.Anthemblue.com
Health Savings Account	Bank of America/Merrill Lynch	800-718-6710	Enrollment link: myhealth.bankofamerica.com/login.aspx?sec=BSB-FPM395 Account Maintenance: Myhealth.bankofamerica.com
Flexible Spending Accounts	Employee Benefits Corporation (EBC)	800-346-2126	www.ebcflex.com Email: participantservices@ebcflex.com
Life and AD&D Insurance	Unum	866-679-3054	www.unum.com
Disability	Unum	866-679-3054	www.unum.com
Accident Insurance	Cigna	800-754-3207	www.mycigna.com
Cancer/Specified Illness Insurance	Cigna	800-754-3207	www.mycigna.com
Hospital Indemnity Insurance	Cigna	800-754-3207	www.mycigna.com
Pet Wellness Program	Wagmo	855-836-8785	wagmo.io
Previ Discount Program	Previ Benefits	801-437-0620	previ.com/benefit/fingerpaint-group
Legal Plan	Legal Club of America	800-305-6816	www.legalclub.com
Student Loan Paydown Program	Gradifi	844-GRADIFI (472-3434)	www.gradifi.com
Employee Assistance Program (EAP)	Health Advocate courtesy of Unum	800-854-1446	www.unum.com/lifebalance
401(k) Retirement Savings Plan	Principal	800-547-7754	www.principal.com
Decision Support Tool	Hyke (Formerly Decision Doc)	N/A	questions@letshyke.com
Advocacy	Health Advocate	866-989-2942	Email: answers@healthadvocate.com URL: healthadvocate.com/healthadvocacyplus Registration Code: WTWHAPLUS
HR and Benefits	Fingerpaint	N/A	People&culture@fingerpaint.com

Annual Notices

HIPAA Special Enrollment Notice

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 enroll yourself or 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). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as 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.

Special enrollment rights also may exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP) coverage, and you request enrollment within 60 days after that coverage ends; or
- If you or your dependents become eligible for a state premium assistance subsidy through Medicaid or a state CHIP with respect to coverage under this plan and you request enrollment within 60 days after the determination of eligibility for such assistance.

Note: The 60-day period for requesting enrollment applies only in these last two listed circumstances relating to Medicaid and state CHIP. As described above, a 30-day period applies to most special enrollments.

As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage may eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you may not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraphs above, however, regarding enrollment in the event of marriage, birth, adoption, placement for adoption, loss of eligibility for Medicaid or a state CHIP, and gaining eligibility for a state premium assistance subsidy through Medicaid or a state CHIP.)

To request special enrollment or obtain more information, contact Human Resources.

Women's Health and Cancer Rights Act Notice

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply for the three medical plans:

- $750 PPO deductible with 20% coinsurance
- $2,000 EPO deductible with 30% coinsurance
- $3,500 EPO HSA deductible with 30% coinsurance

If you would like more information on WHCRA benefits, call your plan administrator at 518-693-6960.

Annual Notices (Continued)

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 January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Annual Notices (Continued)



GEORGIA – Medicaid

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

INDIANA – Medicaid

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

IOWA – Medicaid and CHIP (Hawki)

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

KANSAS – Medicaid

Website: 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: chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid

Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana
Medicaid Customer Service Line: 1-888-342-6207
Louisiana Medicaid email: healthy@la.gov
Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp
LaHIPP phone: 1-877-697-6703
LaHIPP email: La.HIPP@la.gov
LaHIPP fax: 1-888-716-9787
LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084

MAINE – Medicaid

Enrollment Website: www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage: www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

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

MISSOURI – Medicaid

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

MONTANA – Medicaid

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

NEBRASKA – Medicaid

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

NEVADA – Medicaid

Medicaid Website: dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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

Annual Notices (Continued)



NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: www.insureoklahoma.org Phone: 1-888-365-3742	Website: healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA – Medicaid**
Website: www.scdhhs.gov Phone: 1-888-549-0820	Website: dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: medicaid.utah.gov/buyout-program/ CHIP Website: chip.utah.gov/
VERMONT – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: coverva.dmas.virginia.gov/learn/premium-assistance/famis-select coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: www.hca.wa.gov/ Phone: 1-800-562-3022	Website: dhhr.wv.gov/bms/ mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

Annual Notices (Continued)

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 4/30/2026)

Michelle's Law Notice

The Fingerpaint Health and Welfare Benefits Plan (the "Plan") currently permits an employee to continue a child's coverage until the child's 26th birthday if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.

There are two definitions that are important for purposes of determining whether the Michelle's Law extension of eligibility applies to a particular child:

- Dependent child means a child of a plan participant who is eligible under the terms of a group health benefit plan based on his or her student status and who was enrolled at a post-secondary educational institution immediately before the first day of a medically necessary leave of absence.
- Medically necessary leave of absence means a leave of absence or any other change in enrollment:
  - of a dependent child from a post-secondary educational institution that begins while the child is suffering from a serious illness or injury;
  - which is medically necessary;
  - and which causes the dependent child to lose student status under the terms of the Plan.

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility). If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

- One year after the first day of the leave of absence; or
- The date that Plan coverage would otherwise terminate (for reasons other than failure to be a full-time student).

Annual Notices (Continued)



A dependent child on a medically necessary leave of absence is entitled to receive the same Plan benefits as other dependent children covered under the Plan. Further, any change to Plan coverage that occurs during the Michelle's Law extension of eligibility will apply to the dependent child to the same extent as it applies to other dependent children covered under the Plan.

CMS Medicare Part D Credible Coverage Disclosure Notice

Important Notice from Fingerpaint Group 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 Fingerpaint Group 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:

- **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.**
- **Fingerpaint Group has determined that the prescription drug coverage offered by the Fingerpaint Group Health and Welfare Benefits Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Fingerpaint Group coverage will [or will not] be affected. If you do decide to join a Medicare drug plan and drop your current Fingerpaint Group 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 Fingerpaint Group 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.

Annual Notices (Continued)



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 Fingerpaint Group changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: 7/1/2026
Name of Entity/Sender: Fingerpaint Group
Contact–Position/Office: Maggie Thompson

Address: 468 Broadway Suite 2A
Saratoga Springs, NY 12866
Email: maggie.thompson@fingerpaint.com

General Notice of COBRA Continuation Coverage Rights

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.

Annual Notices (Continued)



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.

Annual Notices (Continued)



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 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.

Annual Notices (Continued)



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

Fingerpaint Group
Maggie Thompson
maggie.thompson@fingerpaint.com

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOU MAY OBTAIN A COPY OF THE PLAN'S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES THE WAYS THAT THE PLAN USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION.

Fingerpaint Group (the "Plan") provides health benefits to eligible employees of **Fingerpaint Group** (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact **Human Resources**, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights.

Newborn's and Mother's 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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Annual Notices (Continued)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October for coverage starting as early as January 1.

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

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.12% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

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

1 An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

About this Guide

This benefit summary provides selected highlights of the Fingerpaint Group benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Fingerpaint Group reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.