CAMUNDA

EMPLOYEE BENEFITS GUIDE 2022

CLICK TO BEGIN

1 | ELIGIBILITY

What is a Full Time Employee?	A Full Time Employee is an employee actively working on average 30 or more hours per work week
Who's eligible to enroll?	All full-time employees, as well as their eligible dependents
Who are your eligible dependents?	Spouse, Domestic Partner, Child(ren) under the age of 26, and Child(ren) of Domestic Partner under the age of 26
When am I eligible to enroll?	You become eligible for Camunda's benefits on your date of hire
When can my eligible dependents enroll?	The date you are eligible to enroll or the date you gain the dependent (i.e., get married, birth, adoption, etc.)
When can I change my elections?	• During Camunda's annual open enrollment, you may make any change in election that you want to • You can change your coverage type only if you have a qualifying event (ie change in marital status, or when there is a birth or adoption) • You have an increase or reduction of hours that changes your eligibility status
Imputed Income Disclaimer	Imputed income will apply for costs related to Domestic Partners or Ex-spouses. Please contact HR for more information on these costs.

2 | COSTS & CONTACTS

Imputed income will apply for costs related to Domestic Partners or Ex-spouses. Please contact HR for more information on these costs.

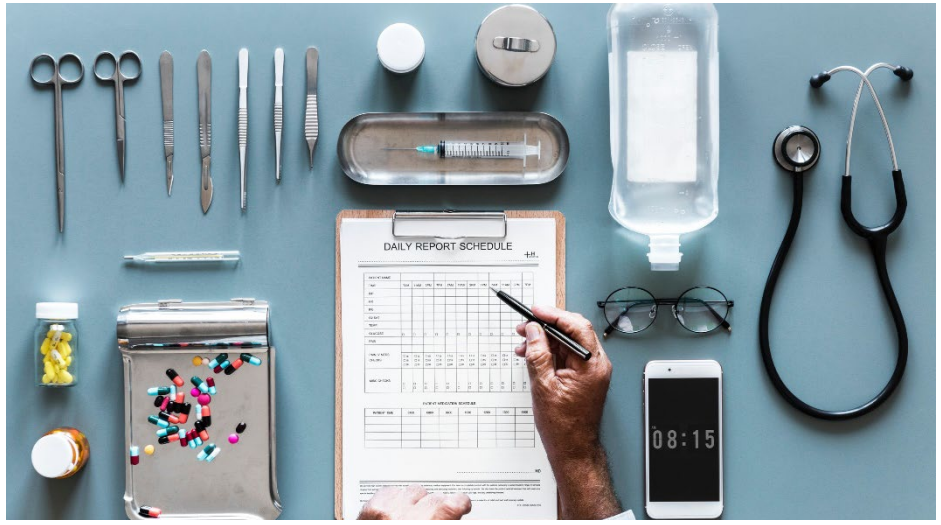
CAMUNDA BENEFIT	WHO PAYS?	EMPLOYEE COST PER PAY PERIOD		MEMBER SERVICES	ONLINE PORTAL
MEDICAL - BCBS PPO HRA	Camunda & you share the cost of your monthly medical premiums	Employee Employee + Spouse Employee + Child(ren) Family	$39.78 $119.33 $107.08 $240.62	(800) 262-2583	Blue Cross Blue Shield Member Portal
MEDICAL - BCBS PPO HSA		Employee Employee + Spouse Employee + Child(ren) Family	$0.00 $0.00 $0.00 $0.00		
DENTAL – METLIFE PASSIVE PPO	Camunda & you share the cost of your monthly dental premiums	Employee Employee + Spouse Employee + Child(ren) Family	$0.25 $5.75 $6.00 $13.50	(800) 942-0854	MetLife Member Portal
VISION – VSP	You cover the cost of your monthly vision premiums	Employee Employee + Spouse Employee + Child(ren) Family	$3.70 $5.92 $6.05 $9.75	(800) 877-7195	VSP Member Portal
HEALTH EQUITY FLEXIBLE SPENDING / DEP CARE ACCOUNT	You are the sole contributor to your FSA & Dep Care Account	Eligible Employees	Varied	(866) 346-5800	Health Equity Member Portal
HEALTH EQUITY HEALTH REIMBURSMENT ACCOUNT	Camunda is the sole contributor to your HRA accounts	Employee Employee + Spouse Employee + Child(ren) Family	$1,750 $3,500 $3,500 $3,500		
HEALTH EQUITY HEALTH SAVINGS ACCOUNT	Camunda contributes to your HSA annually, you may contribute as well	Employee Employee + Spouse Employee + Child(ren) Family	$2,000 $4,000 $4,000 $4,000		
SUNLIFE BASIC LIFE & DISABILITY	Camunda pays 100% of your Basic Life and AD&D/ Disability Premiums	Eligible Employees	$0	(800) 786-5433	SunLife Portal
SUNLIFE VOLUNTARY LIFE & AD&D	You pay 100% of your Voluntary Life and AD&D premiums	Eligible Employees	Varies by age		

3 | MEDICAL – BLUE CROSS BLUE SHIELD

	BLUE CROSS BLUE SHIELD PPO HRA		BLUE CROSS BLUE SHIELD PPO HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Individual/Family)	$250/$500	$4,000/$8,000	$3,000/$6,000	$6,000/$12,000
Out of pocket Max (Individual/Family)	$6,500/$13,000	$13,000/$26,000	$6,850/$13,700	$13,700/$27,400
Preventive Office Visit	$0	Deductible then 20% Coinsurance	$0	Deductible then 20% Coinsurance
Office Visit: PCP/Specialist	$50 Copay	Deductible then 20% Coinsurance	Deductible then $35/$55 Copay	Deductible then 20% Coinsurance
Diagnostic Tests (MRI, Labs, CT, X-Rays)	Deductible then $0	Deductible then 20% Coinsurance	Deductible then $0	Deductible then 20% Coinsurance
Urgent Care	$50 Copay	Deductible then 20% Coinsurance	Deductible then $55	Deductible then 20% Coinsurance
Emergency Room	$300 Copay		Deductible then $400 Copay	
Inpatient Care	Deductible then $0	Deductible then 20% Coinsurance	Deductible then $500 Copay	Deductible then 20% Coinsurance
Outpatient Surgical	Deductible then $0	Deductible then 20% Coinsurance	Deductible $250 Copay	Deductible then 20% Coinsurance
Prescriptions - Retail/Mail Low-Cost Generic Preferred Brand Non-Preferred Specialty	$5/$10 $30/$60 $60/$120	$5/$10 $30/$60 $60/$120	$5/$10 $30/$60 $80/$160	$5/$10 $30/$60 $80/$160

Find a medical provider

Your medical plan comes with several perks, including a fitness reimbursement, weight-loss reimbursement, telehealth, product & service discounts through Blue365, a mobile app, and more. Click to learn more.



4 | MEDICAL – BLUE CROSS BLUE SHIELD

BCBS PERKS FOR MEDICAL SUBSCRIBERS	
Well-Connection	BCBS offers on-demand medical care and therapy. You can get help for illnesses such as cold, fever, sore throats and more for the same cost as a doctor office visit. All you need to do it log into your MYBLUE account and use the Well-Connection link.
Fitness Reimbursement	One reimbursement per family each calendar year for up to $150 for membership fees or fitness classes. Use at full-service Health Club with cardiovascular & strength-training equipment like treadmills, bikes, weight machines & free weights, or at a fitness studio for yoga, Pilates, Zumba, kickboxing, indoor cycling/spinning, etc.
Weight-loss Reimbursement	One reimbursement per family each calendar year for up to $150 for participation fees. Can be used on hospital-based programs, Weight Watchers in person or online, non-hospital programs that combine healthy eating, exercise & coaching sessions with certified health professionals such as nutritionists, registered dieticians, or exercise physiologists
Ahealthmerewards	Register on ahealthymerewards.com, download the virgin pulse mobile app and start tracking your health activities! You can earn up to $400 annually for your healthy habits.
Blue365 Discounts	Access to discounts on things like on gym memberships, fitness gear, healthy eating options and more.

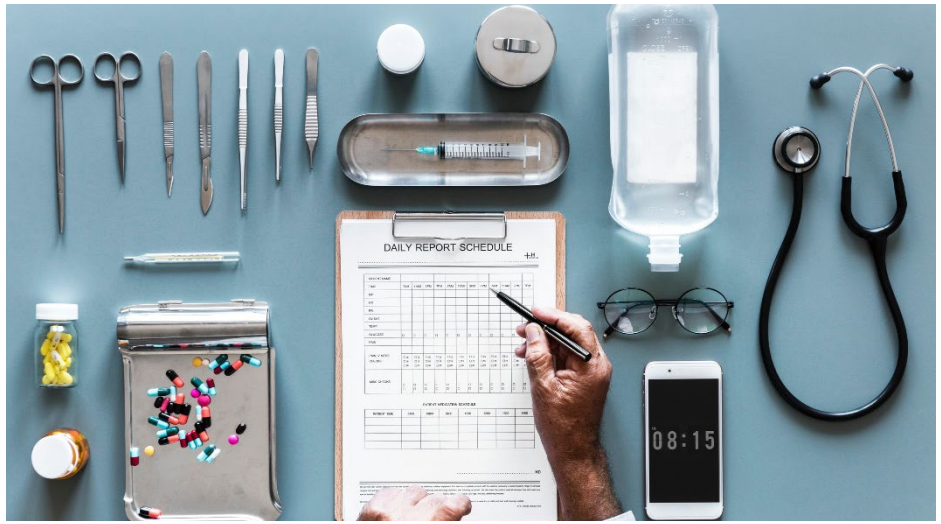
Get paid for being healthy!

Don't miss out on your reimbursements:

Fitness Reimbursement Form

Weight Loss Reimbursement Form

Visit the e-kit for more information



5 | HEALTH REIMBURSEMENT ACCOUNT– HEALTH EQUITY

HealthEquity
Building Health Savings

HEALTH REIMBURSEMENT ACCOUNT (HRA)	
Camunda Annual Contribution	Camunda contributes $1,750 per calendar year to individuals, and $3,500 per calendar year to families
Eligible Expenses	Deductible expenses only
Plan Administrator	Health Equity
Plan Requirements	Must be enrolled in Camunda's PPO HRA Plan. You are automatically set up with an HRA if enrolled in this plan.
How to use funds	Reimbursement is automatically applied to eligible expenses
Account Owner	The funds are owned by Camunda and do not transfer with you when you leave Camunda

How does the HRA work?

The HRA is put in place to cut down your deductible expenses. Individuals are responsible to pay the first $250 and families the first $500 of their deductibles, and then Camunda covers the other portion.

6 | HEALTH SAVINGS ACCOUNT – HEALTHY EQUITY

HealthEquity
Building Health Savings

HEALTH SAVINGS ACCOUNT (HSA)	
Maximum Annual Contribution	Individuals may contribute up to $3,650 per calendar year. Families may contribute up to $7,300 per calendar year
Camunda Annual Contribution	Camunda contributes $2,000 per calendar year to individuals, and $4,000 per calendar year to families
Eligible Expenses	Medical, Dental & Vision. View the full list
Plan Administrator	Health Equity
Plan Requirements	Must be enrolled in Camunda's HSA plan
How to use funds	Use your Health Equity debit care at point of service, or submit for reimbursement online
Account Owner	You own this account. The funds remain there until you use or invest them

Triple Tax Savings

HSA accounts provide tax savings in three ways:

- Funds are not taxed when they are contributed
- You don't pay taxes for any funds while they are in your account
- Funds that are spent on qualified expenses are not taxed

7 | FLEXIBLE SPENDING ACCOUNTS – HEALTH EQUITY

HealthEquity
Building Health Savings

	MEDICAL FSA	DEPENDENT CARE FSA
Maximum Annual Contribution	You can contribute up to $2,850 annually	You can contribute up to $5,000 annually
Eligible Expenses	Medical, Dental and Vision View the full list	Childcare & Eldercare View the full list
Rollover	$570	There is not rollover for DCFSA; funds not used are forfeited
Plan Administrator	Health Equity	
How to use funds	Request reimbursement after expenses are incurred; or use your Health Equity debit card at point of service	Submit for reimbursement after expenses are incurred

With a flexible spending account (FSA), you can have a portion of your paycheck contributed pre-tax to pay for qualified expenses

Maximum Annual Contribution

Dependent Care - $5,000 per household
Medical FSA - $2,850

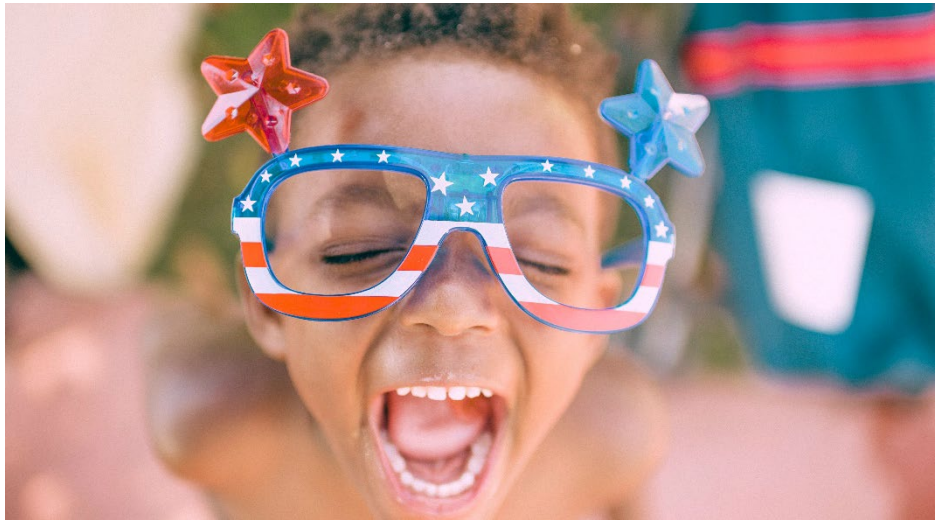
8 | DENTAL – METLIFE

MetLife

METLIFE PASSIVE PPO	
Deductible Deductible waived for preventive services	$50/$150
Out-of-Pocket Max	$2,000
Preventive Care (cleanings)	100% covered
Basic Care (fillings)	80% covered
Major Care (crowns, dentures)	50% covered
Orthodontia	50% covered for children up to lifetime max of $1,500

Find a dental provider

Your dental plan allows you two free dental cleaning a year, and one routine x-ray every 12 months.



9 | VISION – VSP

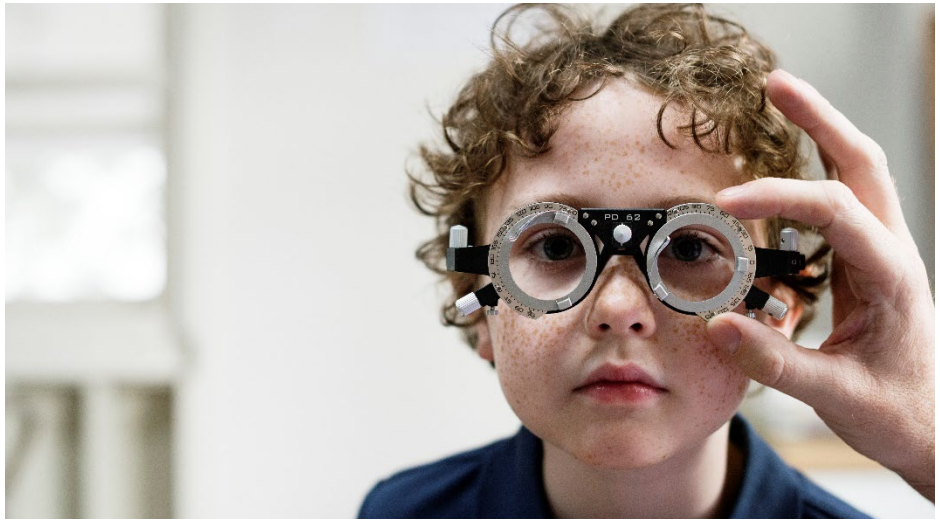
VSP Vision care for life

VSP VISION		
	In-Network	Frequency
Exam	$10 copay	Every 12 months
Frames	$130 allowance with an additional 20% off balance	Every 24 months
Lenses	Included in prescription glasses copay	Every 12 months
Contact Lenses (Instead of glasses)	$130 allowance, copay does not apply	Every 12 months
Contact Lens Exam	Up to $60 copay	Every 12 months

Find an eye doctor

VSP offers several member perks, like:

- Get an extra $20 to spend on feature frame brands for both glasses and sunglasses.
- Receive 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your exam, or get 20% off from any VSP provider within 12 months of your last exam.
- Get 15% off laser correction or 5% off sale price.



10 | BASIC LIFE AND AD&D INSURANCE– SUNLIFE

Sun Life

SUNLIFE LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT	
Basic Life Coverage Amount	1.5x your salary up to $250,000
Basic AD&D Coverage Amount	1.5x your salary up to $250,000
Guaranteed issue	No medical questions asked, up to Guaranteed Issue amount of $250,000
Age Reduction	Benefit reduces to 60% at age 70
Disclaimer	IRC section 79 provides an exclusion for the first $50,000 of group-term life insurance coverage provided under a policy carried directly or indirectly by an employer. The imputed cost of coverage in excess of $50,000 must be included in income, using the IRS Premium Table, and are subject to social security and Medicare taxes

Q & A

Q. What is age reduction?

A. Age reduction is the schedule in which your benefit amount begins to reduce. The age reductions begins at age 70.

For example, if you make $100,000 annually and you turn 70, your coverage for both basic life and AD&D goes from $150,000 (1.5x your annual salary) to $60,000 – a 60% reduction.

11 | VOLUNTARY LIFE AND AD&D INSURANCE – SUNLIFE

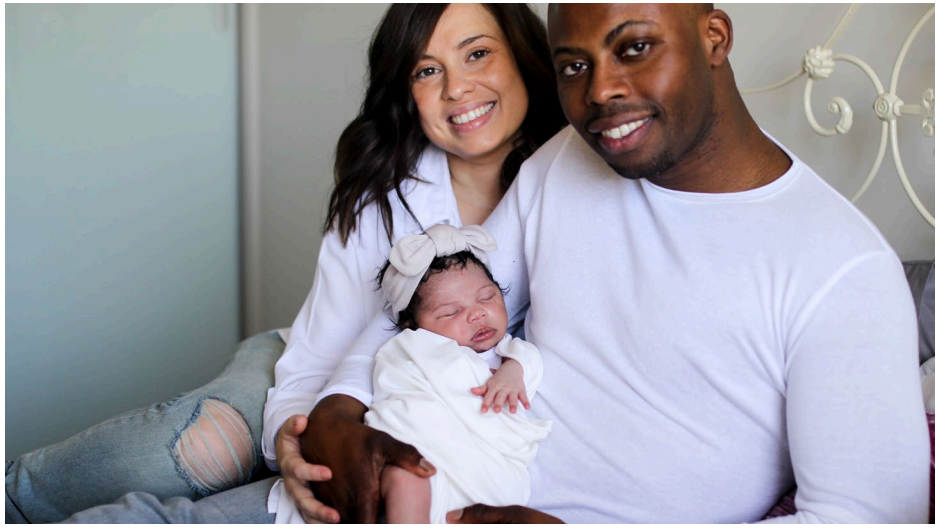
Sun Life

SUNLIFE VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT	
Employee Coverage	Up to $500,000 in increments of $10,000 – not to exceed 5x annual salary. Guaranteed issue is $100,000
Spouse Coverage	Up to $150,000 in increments of $5,000 – not to exceed 50% of employee's voluntary election. Guaranteed issue is $30,000
Child Coverage	Up to $10,000 in increments of $1,000 – not to exceed 50% employee's voluntary election. Guaranteed issue is $10,000
Requirements	The employee must elect the benefit for themselves in order to elect the coverage for a spouse/partner and/or children. Employees pay 100% of the premium for this benefit. Please see the information provided by Camunda for rates.

Q & A

Q. What amount can I get covered up to before I am asked medical questions?

A. No medical questions asked, up to Guaranteed Issue amount.



12 | DISABILITY INSURANCE – SUNLIFE

Sun Life

SUNLIFE SHORT TERM DISABILITY PLAN FEATURES	
Benefit Percentage	60% of your base weekly earnings
Maximum Weekly Benefit	$100
Maximum Benefit Period	24 weeks
Elimination Period	Benefit begins on the 15th day for both injury or illness
Camunda Coverage	40% of base salary while out on Disability
SUNLIFE LONG TERM DISABILITY PLAN FEATURES	
Benefit Percentage	60% of your base monthly earnings
Maximum Monthly Benefit	$10,000
Maximum Benefit Period	Up to Social Security Normal Retirement Age
Elimination Period	Benefit begins on the 181st day
Pre-existing Exclusion	3/12
Own Occupation Duration	24 months

What is a Pre-existing condition?

This is an illness or injury for which you received treatment within the 3 months prior to your effective date of coverage. Disabilities that occur during the first 12 months of coverage due to a pre-existing condition are excluded. So, for example, if you have a diagnosed heart condition within 3 months prior to getting coverage, then have a heart attack within 12 months of being covered, you will not receive this benefit

13 | EMPLOYEE ASSISTANCE PROGRAM – SUNLIFE

Sun Life

EMPLOYEE ASSISTANCEE PROGRAM	
Confidential Counseling on personal issues	Get confidential counseling by experienced clinicians over the phone 24 hours a day, seven day a week
Financial Information	Financial issues can arise at any time, from dealing with debt to saving for retirement. Our financial professionals are here to discuss your concerns and provide you with the tools and information you need to address your finances including getting out of debt, retirement, tax questions and more
Legal information	When a legal issue arises, our attorneys are available to provide confidential support with practical, understandable information and assistance.
Online Information	Access expert information to assist you with the issues that matter to you, from personal or family concerns to legal and financial concerns.

How to Access

You are automatically enrolled in the Camunda EAP . This benefit is provided by SunLife Insurance through ComPsych.

To get help call (800) 460-4374 or visit: guidanceresources.com – using the WEBID: EAPessential

14 | EMPLOYEE SUPPORT - TOUCHCARE

TOUCHCARE
A healthier understanding of healthcare.

TOUCHCARE

What is TouchCare?	A personal health assistant, that is available to provide free, confidential assistance on your healthcare choices.

Benefit Navigation
Touchcare can assist you with all aspects of benefits including your tax savings accounts

Bill Negotiation
Send your bills to TouchCare and work through anything you feel is incorrect

Cost Comparison
Ensure you never overpay for your care by carefully researching all options and cost

Provider Search
TouchCare will always navigate you to highly-rated providers that are in-network and conveniently located

RxCare
Get assistance on finding the lowest cost options for all your prescriptions

Ancillary Benefits
TouchCare will help you leverage the right benefit, at the right time to save you money

Benefit Refresher
Consult with an expert regarding your benefits anytime throughout the year

Questions
If you have any questions, your Health Assistance is always there to help

How to get help:

You can reach your Health Assistance by calling (866) 486-8242 anytime Monday – Friday from 8am – 9pm EST.

You can also visit the TouchCare member portal or emailing assist@touchare.com

15 | CAMUNDA PERKS

PARENTAL LEAVE

All active full-time employees with 6 months of service are eligible to participate

20 Weeks of paid leave at 100% of your base salary

Both “maternity” and “paternity” leaves are covered under this policy

This leave runs concurrent with any other leave policies or statutory requirements

Please see our Parental Leave Policy for more information

UNLIMITED FLEXIBLE TIME OFF (FTO)

No set number of hours and no accrual

Covers all time off including vacation, personal and sick days

Employees can take time off when they need it with manager approval

Any absences greater than 20 consecutive days are considered a leave of Absence

Please see our Unlimited Flexible Time Off Policy for more information

16 | 401(K) RETIREMENT PLAN – ADP RETIREMENT SERVICES

Guideline

ADP 401(K) RETIREMENT PLAN	
Pre-tax 401(k) & Roth 401(k)	$20,500
Catch up contribution (age 50+)	An additional $6,500 annually
Eligibility	Must be 18 years of age. Eligible on Date of Hire
Employer Match	100% of employee's first 6% of contributions
Plan Administrator	Guideline

Additional Information

Employees will receive an automated email with instructions for enrolling or declining. Employees will be automatically enrolled if they do not decline themselves

Caumunda's employee match is immediately vested

17 | HEALTH PLAN NOTICES

1. Special Enrollment Rights - If you do not enroll yourself and your dependents in a group health plan after you become eligible or during annual enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you declined coverage because you had other health care coverage that you have now lost through no fault of your own (or employer contributions to your other health care coverage terminate); or (ii) you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. When you have previously declined coverage, you must have given (in writing) the alternative coverage as your reason for waiving coverage under the group health plan when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the group health plan if you provide notice to the Plan Administrator within 30 days after you lose your alternative coverage (or employer contributions to your alternative coverage cease) or the date of your marriage or the birth, adoption, or placement for adoption of your child. See the Plan Administrator for details about special enrollment

2. CHIP - You may also enroll yourself and your dependents in a group health plan if you or one of your eligible dependent's coverage under Medicaid or the state Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, or if you or one of your eligible dependents become eligible for premium assistance under a Medicaid or CHIP plan. Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid/CHIP coverage or of the determination of eligibility for premium assistance under Medicaid/CHIP. See the Plan Administrator for details about special enrollment.

3. Grandfathered Status - The Plan believes that none of the group health plans available under the Plan are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the "Affordable Care Act").

4. Special Rule for Maternity and Infant Coverage - 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 attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable).

5. Special Rule for Women's Health Coverage - The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers, and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas.

6. Notice Regarding Lifetime and Annual Dollar Limits - In accordance with applicable law, none of the lifetime dollar limits and annual dollar limits set forth in the Plan shall apply to "essential health benefits," as such term is defined under Section 1302(b) of the Affordable Care Act. The law defines "essential health benefits" to include, at minimum, items and services covered within certain categories including emergency services, hospitalization, prescription drugs, rehabilitative and habilitative services and devices, and laboratory services, but currently provides little further information. Accordingly, a determination as to whether a benefit constitutes an "essential health benefit" will be based on a good faith interpretation by the Plan Administrator or the guidance available as of the date on which the determination is made.

7. Patient Protection Disclosure - You have the right to designate any participating primary care provider who is available to accept you or your family members (for children, you may designate a pediatrician as the primary care provider). For information on how to select a primary care provider and for a list of participating primary care providers, contact the Plan Administrator. You do not need prior authorization from the Plan or from any other person, including your primary care provider, in order to obtain access to obstetrical or gynecological care from a health care professional; however, you may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

8. Affordable Care Act Consumer Protections - (a.) Coverage for Children Up to Age of 26 The Affordable Care Act of 2010 requires that the Plan must make dependent coverage available to adult children until they turn 26 regardless if they are married, a dependent, or a student. (b.) Prohibition of Lifetime Dollar Value of Benefits The Affordable Care Act of 2010 prohibits the Plan from imposing a lifetime limit on the dollar value of benefits. (c.) Your Health Insurance Cannot be Rescinded The Affordable Care Act of 2010 prohibits the Plan, or any insurer, from rescinding your health insurance coverage except as permitted under the Act. (d.) Prohibition of Pre Existing Conditions Effective January 1, 2014 The Affordable Care Act of 2010 prohibits the Plan, or any insurer, from denying any health insurance claim for any person because of pre-existing condition. (e.) Prohibition of Restrictions on Annual Limits on Essential Benefits The Affordable Care Act of 2010 prohibits the Plan, or any insurer, effective January 1, 2014 from placing annual limits on the value of essential health benefits.

9. Michelle's Law - Michelle's Law provides continued health and dental insurance benefits under the Plan for dependent children who are covered under the Plan as a student but lose their student status in a post-secondary school or college because they take a medically necessary leave of absence from school. If your child is no longer a student because he or she is out of school because of a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence.

10. The Genetic Information Nondiscrimination Act (GINA) - GINA prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any benefits under the Plan. Genetic information includes the results of genetic tests to determine whether someone is at increased risk of acquiring a condition in the future, as well as an individual's family medical history.

11. Wellness - If your Plan includes a Wellness program that provides rewards or surcharges based on your ability to complete an activity or satisfy an initial health standard, you have the right to request a reasonable alternative should it be determined that it is not medically advisable for you to either complete the activity or satisfy the initial health standard.

18 | IMPORTANT NOTICE FROM CAMUNDA 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 Camunda and about your options under Medicare's prescription drug coverage. This information can help you decide whether 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. Camunda has determined that the prescription drug coverage offered by the following plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are 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.

   Blue Cross Blue Shield – PPH HSA and PPO HRA Plans

Q. When Can You Join A Medicare Drug Plan?

A. 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.

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

A. Your current coverage pays for other health expenses, in addition to prescription drugs. If you are actively employed with Camunda and decide to join a Medicare drug plan, your current Camunda medical coverage will not be affected; you can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you are actively employed with Camunda and you decide to join a Medicare drug plan and drop your current Camunda medical coverage, be aware that you and your dependents may be able to get this coverage back at the next open enrollment period or upon a qualifying status change if you remain otherwise eligible to enroll in the Plan.

If you are no longer actively employed by Camunda and you decide to join a Medicare drug plan and drop your current Camunda coverage, be aware that you and your dependents will not be able to get this coverage back.

Q. When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

A. You should also know that if you drop or lose your current coverage with Camunda 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 19 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) while you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Nuvolo changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: January 1, 2022
Name of Entity/Sender: Camunda, Inc
Contact: Emily Harris

Address: 303 Wyman Street Waltham, MA 02451
Phone: (415) 513 - 0111

19 | YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay, and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

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

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

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

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

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

If you believe you've been wrongly billed, you may contact the Centers for Medicare & Medicaid Services https://www.cms.gov/nosurprises

Visit https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets for more information about your rights under federal law.