2026

Employee Benefits Guide

Residential CRF, Inc.

ApexBenefits

Table of Contents

Click title to navigate to the page

The employee benefit programs described in this guide are a summary of benefits, and every attempt has been made to ensure its accuracy. The actual provisions of each benefit program will govern if there is any inconsistency between the information in this guide and your group Plan Documents, Summary Plan Descriptions, programs, policies, or contracts or any subsequent change in such plans, programs, policies, or contracts. All information is confidential pursuant to the Health Insurance and Portability Act of 1996.

Benefits Overview

Residential CRF, Inc. offers you and your eligible family members a comprehensive and valuable benefits program. We encourage you to take the time to educate yourself about your options and choose the best coverage for you and your family.

Who is Eligible?

If you are a full-time employee (working 30 or more hours per week), you are eligible to enroll in the benefits described in this guide. The following family members are eligible for medical coverage: legal spouse, subscriber's natural child, stepchild, or child placed by adoption, as well as, subscriber's grandchild, blood relative or other child for whom legal guardianship has been awarded to the subscriber or the subscriber's spouse.

NEW HIRES: Newly Eligible employees will become eligible for benefits effective 60 days after their date of hire.

OPEN ENROLLMENT: The benefits you elect will be effective January 1, 2026.

You must enroll during Residential CRF, Inc.'s annual Open enrollment period, January 1-31. 2026. If you miss these enrollment opportunities, you must wait until next year's Open Enrollment period unless you have a qualifying life event.

How to Make Changes

A life event change (qualifying event) is a personal change in status which may allow you to change your benefit elections.

Examples of qualifying events include:

- Marital Status Change: Marriage, Divorce, Legal Separation
- Dependent Status Change: Birth, Death, Adoption
- Change in Employment: Full-time to Part-Time or vice versa

If you experience a life event change, you will need to request to change your benefits within 30 calendar days of the event and provide documentation to Human Resources.

Helpful Contacts

Medical	Auxiant	1-800-475-2232 X 1234	www.auxiant.com
RX	TrueRx	1-866-921-4047	www.truerx.com/members
Dental	Auxiant	1-800-475-2232 X 6263	www.auxiant.com
Vision	Auxiant	1-800-475-2232 X 1234	www.auxiant.com
Human Resources	Lisa Achgill	765-825-5129	lisa.achgill@rescrf.com
Federal Notices	Click here to access your 2025 Federal Notices		

Preferred Provider Organization (PPO) Plan

Residential CRF offers a PPO plan that allows you the freedom to use providers in-network and out-of-network as designated in the following chart. This chart gives a side-by-side look at the amounts you pay when you use in-network versus out-of-network providers.

Plan Feature	In-Network	Out-of-Network
Preventive Care Services	Covered in Full	Deductible & Coinsurance
Office Visit		
- Primary care	$25/visit deductible does not apply	$35 Copay then Deductible & Coinsurance
- Specialist	$50/visit deductible does not apply	$50 Copay then Deductible & Coinsurance
Annual Deductible - Individual / Family	$1,500 / $3,000	$1,500 / $3,000
Employee Coinsurance	20%	40%
Out-of-Pocket (Includes Deductible) - Individual / Family	$2,500/ $5,000	$5,000/ $10,000
Urgent Care	$30 Copay then Coinsurance	$30 Copay then Coinsurance
Emergency Room	$200 Copay then Coinsurance	$200 Copay then Coinsurance
Inpatient Services	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Services	Deductible & Coinsurance	Deductible & Coinsurance
Home Health Care	Deductible & Coinsurance	Deductible & Coinsurance
Therapy (Occupational, Physical, Speech)	Deductible & Coinsurance	Deductible & Coinsurance
X-Ray and Laboratory Services	Deductible & Coinsurance	Deductible & Coinsurance
Mental Health & Substance Abuse Services	$25 Copay	$35 Copay then Deductible & Coinsurance

Prescription Plan Features	In-Network	Out-of-Network
Tier 1- Generic	Greater of $10 or 30%	Greater of $20 or 25%
Tier 2- Preferred Brand	Greater of $35 or 30%	Greater of $70 or 25%
Tier 3- Non-Preferred Brand	Greater of $35 or 30%	Greater of $70 or 25%
Tier 4- Specialty (brand and generic)	Specialty Drugs require prior authorization, please call True RX at 866-921-4047.	

Per Pay Rates	Pre- Tax Employee Contribution
Employee Only	$123.48
Employee + Spouse	$321.73
Employee + Child(ren)	$218.64
Employee + Family	$360.37

Dental

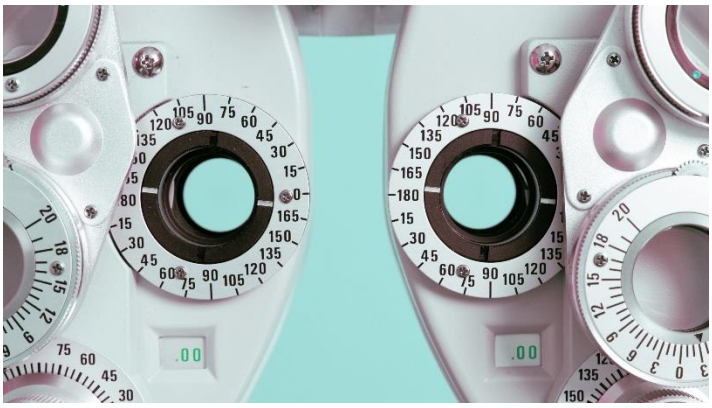
Residential CRF offers dental benefits through Auxiant, which allows you to seek treatment from the dentist of your choice. If an individual is covered by both the Medical and Dental Plan offered by Residential CRF, Medical benefits will be paid prior to Dental and benefits will be coordinated between the two plans.

Rates	Annual Employee Contribution
Per Covered Person	$250

Vision

Residential CRF offers vision benefits through Auxiant, which allows you to seek treatment from an optometrist of your choice. If an individual is covered by both the Medical and Vision Plan offered by Residential CRF, Medical benefits will be paid prior to Vision and benefits will be coordinated between the two plans.

Rates	Annual Employee Contribution
Per Covered Person	$250



Glossary of Terms

Open enrollment is the time of year reserved for you to make changes to your benefit elections, and unfamiliar terms can make this process confusing. Use these definitions of common enrollment terms to help you navigate your benefits options.

Coinsurance: The amount or percentage that you pay for certain covered health care services under your health plan. This is typically the amount paid after a deductible is met and can vary based on the plan design.

Consumer Driven Health Care (CDHC): Health insurance programs and plans that are intended to give you more control over your healthcare expenses. Under CDHC plans, you can use health care services more effectively and have more control over your health care dollars. CDHC plans are designed to be more affordable because they offer reduced premium costs in exchange for higher deductibles. Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs) are common examples of CDHC plans.

Copayment: A flat fee that you pay toward the cost of covered medical services.

Covered Expenses: Health care expenses that are covered under your health plan.

Deductible: A specific dollar amount you pay out of pocket before benefits are available through a health plan. Under some plans, the deductible is waived for certain services.

Dependent: Individuals who meet eligibility requirements under a health plan and are enrolled in the plan as a qualified dependent.

Employee Contribution: The amount you pay for a health plan in exchange for coverage.

Flexible Spending Account (FSA): An account that allows you to save tax-free dollars for qualified medical and/or dependent care expenses that are not reimbursed. You determine how much you want to contribute to the FSA at the beginning of the plan year. Most funds must be used by the end of the year, as there is only a limited carryover amount.

Health Management Organization (HMO): A type of health insurance plan that usually limits coverage to care from doctors who work for or contract within a specified network. Premiums are paid monthly, and a small co-pay is due for each office visit and hospital stay. HMOs require that you select a primary care physician who is responsible for managing and coordinating all your health care.

Health Reimbursement Arrangement (HRA): An employer-owned medical savings account in which the company deposits pre-tax dollars for each of its covered employees. Employees can then use this account as reimbursement for qualified health care expenses.

Health Savings Account (HSA): An employee-owned medical savings account used to pay for eligible medical expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified period of time. HSAs must be coupled with qualified high-deductible health plans (HDHP).

High Deductible Health Plan (HDHP): A qualified health plan that combines very low monthly premiums in exchange for higher deductibles and out-of-pocket limits. These plans are often coupled with an HSA.

In-network: Health care received from your primary care physician or from a specialist within an outlined list of health care practitioners.

Inpatient: A person who is treated as a registered patient in a hospital or other health care facility.

Medically Necessary (or medical necessity): Services or supplies provided by a hospital, health care facility or physician that meet the following criteria: (1) are appropriate for the symptoms and diagnosis and/or treatment of the condition, illness, disease or injury; (2) serve to provide diagnosis or direct care and/or treatment of the condition, illness, disease or injury; (3) are in accordance with standards of good medical practice; (4) are not primarily serving as convenience; and (5) are considered the most appropriate care available.

Medicare: An insurance program administered by the federal government to provide health coverage to individuals aged 65 and older, or who have certain disabilities or illnesses.

Member: You and those covered become members when you enroll in a health plan. This includes eligible employees, their dependents, COBRA beneficiaries and surviving spouses.

Out-of-network: Health care you receive without a physician referral, or services received by a non-network service provider. Out-of-network health care and plan payments are subject to deductibles and copayments.

Out-of-pocket Expense: Amount that you must pay toward the cost of health care services. This includes deductibles, copayments, and coinsurance.

Out-of-pocket Maximum (OOPM): The highest out-of-pocket amount paid for covered services during a benefit period.

Preferred Provider Organization (PPO): A health plan that offers both in-network and out-of-network benefits. Members must choose one of the in-network providers or facilities to receive the highest level of benefits.

Primary Care Physician (PCP): A doctor that is selected to coordinate treatment under your health plan. This generally includes family practice physicians, general practitioners, internists, pediatricians, etc.

Federal Notices

The following notices are provided to inform you of your rights as an employee. Click the read more links for more information.

Newborns' & Mothers' Health Protection Act

The Newborns' and Mothers' Health Protection Act (the Newborns' Act) provides protections for mothers and their newborn children relating to the length of their hospital stays following childbirth. Under the Newborns' Act, the plan may not restrict benefits for a hospital stay in connection with childbirth to less than 48 hours (96 hours in the case of a cesarean section), unless the attending provider (in consultation with the mother) decides to discharge earlier.

Read more: https://www.dol.gov/general/topic/health-plans/newborns

Women's Health & Cancer Rights Act Of 1998

In accordance with the Women's Health and Cancer Rights Act of 1998, covered members who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to coverage for: Reconstruction of the breast on which the mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetric appearance; Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. The coverage may be subject to coinsurance and deductibles consistent with those established for other benefits.

USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) Advisor assists veterans in understanding employee eligibility and job entitlements, employer obligations, benefits and remedies under USERRA. Your right to continued participation in the Plan during leaves of absence for active military duty is protected by USERRA. Accordingly, if you are absent from work due to a period of active duty in the military for less than 31 days, your Plan participation will not be interrupted. If the absence is for more than 31 days and not more than 12 weeks, you may continue to maintain your coverage under the Plan by paying premiums.

Read more: https://www.dol.gov/agencies/vets/programs/userra

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. If you or your children aren't eligible, 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. 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, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov.

Click this link for contact information for applicable states: new model Employer CHIP Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

Under the Affordable Care Act (ACA), employers covered by the Fair Labor Standards Act (FLSA) are required to provide a notice to employees about the health insurance marketplace/exchanges of the state(s) in which they operate. 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. 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. 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.

Access this statement and forms can be found at: https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/model-notice-for-employers-who-offer-a-health-plan-to-some-or-all-employees.pdf

Employer Notice

Terms of Use: Your Medical Information & Your Rights

This notice from your employer describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have questions, please contact your benefits administrator.

Read more: https://apexbg.com/terms-of-use-your-medical-information-your-rights/

The employee benefit programs described in this guide are effective in 2026. The information in this guide is a summary of your employers' benefits, and every attempt has been made to ensure its accuracy. The actual provisions of each benefit program will govern if there is any inconsistency between the information in this guide and your employer's formal Plan Documents, Plans, Summary Plan Descriptions, programs, policies, or contracts or any subsequent change in such plans, programs, policies, or contracts.