Rimini Street®

# 2025
# Benefit Guide

## Welcome to your Rimini Street Benefits

Rimini Street is committed to providing benefits that focus on protecting your physical, mental, and financial health. We understand that everyone's needs are different and may change from year to year. That's why we offer a variety of plan options, so you can customize your benefits package to fit your lifestyle and your budget. Whatever your well-being goals, Rimini Street offers plans to help you reach them.

Having the right information is key when it's time to make choices about your health benefits. We invite you to explore this guide and discover which plans are best for you. Use this guide as your year-round resource. If you have any questions about your benefits, we are here to help. Reach out to the contacts on page 26.

# WHAT'S INSIDE



*This guide provides an overview of the benefits program. It is not intended to be a complete description of the benefits or official summary plan descriptions for these programs. If there is a conflict between this guide and the official plan documents, the plan documents will govern. Rimini Street reserves the right to modify or terminate any of the described benefits at any time and for any reason. The descriptions of these benefits are not a guarantee of current or future employment or benefits. For information about the specific plans available to you, please contact Benefits at benefits@rimimistreet.com.*

# BENEFIT BASICS

## Eligibility

You are eligible for Rimini Street benefits on your date of hire if you are:

- Active, full-time employee
- Work at least 30 hours per week

### Dependents

Your dependents may enroll in many of the plans you choose for yourself. Proof of dependent status may be required to enroll. Eligible dependents include:

- Your legal spouse or qualified domestic partner
- Your natural, adopted, or stepchildren up to age 26
- Your dependent children of any age, if disabled and incapable of self-support due to mental or physical disability; child must be disabled before reaching age 26

## Making Mid-Year Changes

You can only make changes during the plan year if you have a qualified life event (QLE). Examples of QLEs include:

- Marital status change (marriage, divorce, or legal separation)
- Birth or adoption of a child
- Death of a dependent
- Loss or gain of other health coverage for you and/or dependents
- Change in employment status
- Change in Medicaid/Medicare eligibility for you or a dependent
- Receipt of a Qualified Medical Child Support Order (or other court order)

# HOW TO ENROLL

## New Hires

If you are a newly hired employee, you will have 14 days from your date of hire to enroll in your benefits. Don't miss that deadline because if you do, you will have to wait until the next Open Enrollment period or if you have a QLE to make your benefit elections.

## Open Enrollment

Open Enrollment is the time period where you can select benefits for the next plan year. You can change your current elections, enroll in any new plans, add/remove dependents, and set aside money in a savings or spending account. Rimini's open enrollment period will typically take place in the month of November.  Changes processed during open enrollment are effective January 1 of the following year.

### What Benefits Should I Elect?

No matter if you are a new hire or it's Open Enrollment, there are questions you should always ask to help you understand what benefits may be right for you.

- **How much did I spend on health care last year?** Consider your past expenses to help plan for your future needs.
- **Will I need more, or less, health coverage next year?** Are you having a baby? Considering surgery? Currently in treatment for a chronic condition? Estimate the level of health care you may need in the upcoming year.
- **Should I set aside money in the Health Savings Account or Flexible Spendings Accounts?** You can make pre-tax contributions to pay for eligible out-of-pocket health care expenses.
- **Do I have enough financial protection for my family if something happens to me?** Consider looking at supplemental life insurance.

## Enroll Online

- Visit your Workday chiclet via Okta to enroll.
- Follow the prompts to select or waive each of your benefit options.
- If waiving coverage, follow the prompts online to signify you are waiving coverage.
- Add Beneficiaries
- Submit your elections.

After you submit your elections, review your confirmation statement carefully to make sure your benefits and dependent information are correct.

# TERMS YOU NEED TO KNOW

Before you continue reviewing this guide, it's important that you understand the terms and acronyms you will be reading about.

### Balance Bill

When a health care provider bills a patient for the difference between what the patient's health insurance reimburses and the provider charges.

### Copayment (Copay)

A fixed dollar amount you pay a provider at the time of service.

### Coinsurance

The percentage paid for a covered service, shared by you and the plan. You are responsible for coinsurance until you reach your plan's out-of-pocket maximum.

### Deductible

The amount you pay each year before the plan begins paying for certain services.

### Embedded Deductible

A single covered family member only needs to reach the individual deductible before the plan pays a portion of covered services.

### Formulary

A list of generic and brand-name prescription medications covered by your prescription drug plan.

### In-Network

Care provided by contracted doctors and hospitals within the plan's network of providers. This enables participants to receive care at a reduced rate compared to care received out-of-network.

### Non-Embedded Deductible

A covered family must meet the entire family deductible before the plan pays a portion of covered services.

### Out-of-Network

Care provided by a doctor or at a facility outside of the plan's network. Your out-of-pocket costs may be higher and services subject to balance billing.

### Out-of-Pocket Maximum

The maximum amount you pay each year before the plan begins paying 100% for covered expenses.

### Premium

The amount you pay to have coverage.

### Preventive Care

Routine health care, including annual physicals and screenings, to prevent disease, illness, and other health issues. In-network preventive care is covered at 100%.

### Prior Authorization

The process where physicians and other health care professionals must obtain advance approval from the health plan before a specific service is delivered to the patient to qualify for payment coverage.

### Transition of Care

The movement of a patient from one provider or clinical setting of care to another provider or setting of care. For example, when a primary care provider (PCP) refers a patient to a specialist, or when a hospital discharges a patient to another care setting.

### Usual, Customary, & Reasonable (UCR)

The amount paid for a service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

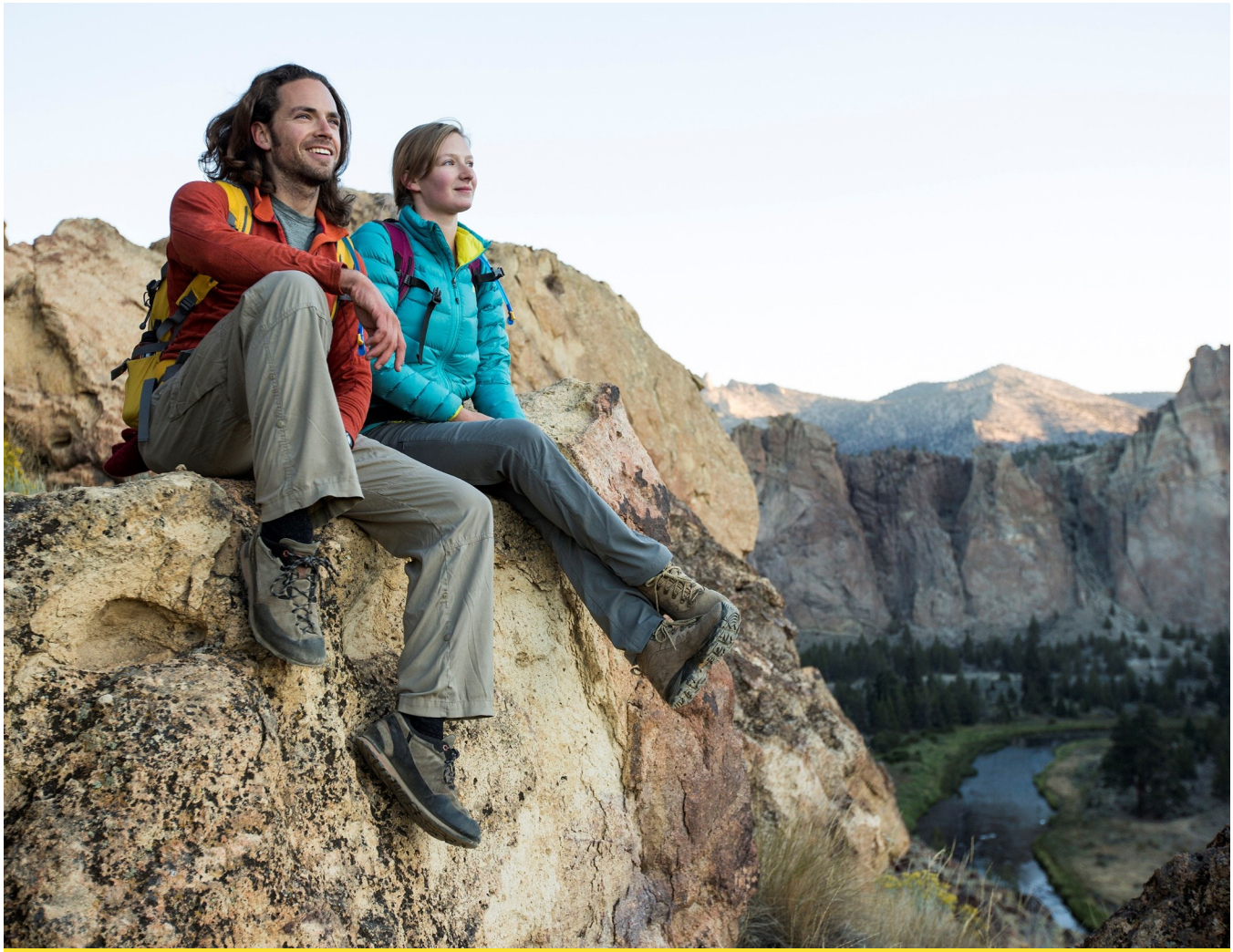
# YOUR EXPERT RESOURCES

## Benefits Information Portal

You have access to benefit information 24/7 through our online benefits website. Access the site through your computer or smartphone web browser: https://www.riministreet.com/benefits/.

No username or password required.

On the site, you'll find plan documents, forms, and are able to watch videos on how our plans work. Bookmark this site and use it year-round.



# HEALTH BENEFITS

Rimini Street offers you four different plan options.

- Kaiser HMO (CA Employees Only)
- United Healthcare 250 and 1500 PPO
- United Healthcare High Deductible Health Plan (HDHP) with Health Savings Account (HSA)

While they all cover in-network preventive care at 100% (dependent on age, gender, and family history), there are some important differences in how the plans work. Let's take a closer look:

| | |
|---|---|
| HMO | • Select a Primary Care Physician (PCP) who will coordinate your health care needs, including referrals to specialists.<br>• Pay a copay for qualified health care services.<br>• Access in-network coverage only. If you visit a provider outside of the plan's network, you will be responsible for the full cost of services. |
| PPO | • Select in-network or out-of-network doctors and facilities. While you can visit any doctor, you'll save the most money by using in-network providers.<br>• Pay a copay for certain services.<br>• Other services may be subject to the annual deductible and coinsurance.<br>• Once you reach the out-of-pocket maximum, the plan will pay 100% for all eligible expenses for the rest of the plan year. |
| HDHP | • Receive care from in-network or out-of-network providers.<br>• Pay for all medical services until you reach the annual deductible, except for in-network preventive care which is covered in full.<br>• Once the annual deductible is met, you and the plan pay a percentage of covered services.<br>• Once the out-of-pocket maximum is reached, the plan will pay for all eligible medical expenses for the rest of the plan year.<br>• When you enroll in the HDHP, you are eligible to open a Health Savings Account (HSA).<br>• The company contributes free money to your HSA. |

## Importance of Using In-Network Providers

In-network providers have agreed to give members a negotiated rate for their services. By using these providers, you save money. Out-of-network providers don't have the same agreement in place, and they can charge you much more for services. Always be sure to double check if your provider or facility is in-network before you make an appointment.

Search for providers anytime:

- Kaiser: www.kp.org
- United Healthcare: www.myuhc.com

## About Your Deductible and Out-of-Pocket Maximum

Depending on the plan you enroll in, the way you meet your family deductible is different.

- PPO and HDHP Plans: These plans have an embedded deductible which means a single covered family member only needs to reach the individual deductible before the plan pays a portion of covered services.
- HMO, PPO and HDHP Plans: These plans have an embedded out-of-pocket maximum which means a single covered family member only needs to reach the individual out-of-pocket maximum before the plan begins paying for all covered services at 100%.

## Prescription Drug Coverage

Prescription drug coverage is included in the medical plan you select. Regardless of which plan you choose, you'll save the most money by using a participating pharmacy. You can access a list of pharmacies through your plan's website or by calling member services on the back of your ID card.

Depending on your plan, prescriptions are covered as follows:

- **HMO and PPO:** You'll pay a flat copay for your prescriptions.
- **HDHP:** Until the deductible is met, you pay 100% of the cost for prescriptions. Once the deductible is met, you share the cost of prescription drugs with the plan.

You can fill prescriptions at a retail location for a **30-day supply** for Kaiser, **31–day supply** for UHC, or by mail order for a **100–day supply** for Kaiser, **90-day supply** for UHC. If you have an ongoing, maintenance prescription, take advantage of saving money by using the mail order program and get your medications delivered right to your door.

## Preventive Care Visits

Prevention is key to catching illnesses early. Preventive care visits, such as your annual wellness check, certain screenings and tests, well-baby and child health care, immunizations, mammograms, and more, are covered in full by your health plan when you use an in-network provider. (Confirm with your doctor that your age, gender, and family history qualify you for no-cost screenings and immunizations.) That's zero dollars out of your pocket! Set a calendar reminder and make it a priority to schedule your annual preventive care visit each year.

| Visits and Exams | Tests |
|---|---|
| • Well-Women<br>• Well-Baby and Child<br>• Annual Exam | • Annual CBC bloodwork at areas such as cholesterol and glucose<br>• Blood Pressure<br>• Diabetes |
| **Vaccinations** | **Cancer Screenings** |
| • Flu<br>• COVID-19<br>• Doctor-recommended based on your age and gender, like polio, shingles, meningitis, and more | • Mammogram<br>• Colonoscopy<br>• PSA<br>• PAP |

Log in to Kaiser's website at www.kp.org or United Healthcare at www.myuhc.com to review their preventive care coverage list. You can also call to confirm what is covered before you receive services.

# Medical Plan Comparison

| Plan Features | Kaiser HMO (CA Employees Only) | United Healthcare HDHP HSA | |
|---|---|---|---|
| | In-Network Only | In-Network | Out-of-Network |
| Calendar Year Deductible *(see pg. 8)* Individual/Family | None | $3,300 / $6,000 | $3,300 / $6,000 |
| Calendar Year Out-of-Pocket Maximum *(see pg. 8)* Individual/Family | $1,500 / $3,000 | $3,500 / $7,000 | $6,000 / $12,000 |
| Rimini Street Annual HSA Contribution Individual/Family | N/A | $1,500 / $2,500 | |
| | You pay: | You pay: | |
| Preventive Care Visit | Covered in full | Covered in full | Not covered |
| Primary Care | $25 copay | 20% after deductible | 40% after deductible |
| Telemedicine Visit | No charge | Telehealth: 20% after deductible | Telehealth: 40% after deductible |
| Specialist Visit | $25 copay | 20% after deductible | 40% after deductible |
| Lab & X– ray | Covered in full | Lab and Imaging: 20% after deductible / 40% after deductible;<br>X-ray: 20% after deductible | X-ray and Imaging: 40% after deductible;<br>Lab: Not covered |
| Urgent Care | $25 copay | 20% after deductible | 40% after deductible |
| Emergency Room | $100 copay (copay waived if admitted) | 20% after deductible | |
| Outpatient Services | $25 copay | 20% after deductible | 40% after deductible (up to $760 / day) |
| Inpatient Services | Covered in full | 20% after deductible | 40% after deductible |
| Chiropractic | Not covered | 20% after deductible (24 visits / year) | Not covered |
| Acupuncture | $25 copay | 20% after deductible (20 visits / year) | Not covered |
| **Prescription Drugs: Retail (up to a 30-day supply for Kaiser, 31-day supply for UHC)** | | | |
| Tier 1<br>Tier 2<br>Tier 3 | $10 copay<br>$25 copay<br>$25 copay | $10 copay after deductible<br>$35 copay after deductible<br>$70 copay after deductible | |
| **Prescription Drugs: Mail Order (up to a 100-day supply for Kaiser, 90-day supply for UHC)** | | | |
| Tier 1<br>Tier 2<br>Tier 3 | $20 copay<br>$50 copay<br>$50 copay | $25 copay after deductible<br>$87.50 copay after deductible<br>$175 copay after deductible | Not covered |

*This chart provides a brief overview of benefits and coverage. Refer to the detailed summary plan documents for questions about a specific procedure, service, or provider. In the event of a conflict, the official plan documents prevail.*

# Medical Plan Comparison Cont.

| Plan Features | United Healthcare PPO 250 | | United Healthcare PPO 1500 | |
|---|---|---|---|---|
| | In-Network | Out-of-Network | In-Network | Out-of-Network |
| Calendar Year Deductible *(see pg. 8)* Individual/Family | $250 / $500 | $500 / $1,000 | $1,500 / $3,000 | $1,500 / $3,000 |
| Calendar Year Out-of-Pocket Maximum *(see pg. 8)* Individual/Family | $2,250 / $4,500 | $4,500 / $9,000 | $4,500 / $9,000 | $7,500 / $15,000 |
| | You pay: | | You pay: | |
| Preventive Care Visit | Covered in full | Not covered | Covered in full | Not covered |
| Primary Care | $20 copay | 40% after deductible | $15 copay | 50% after deductible |
| Telemedicine Visit | Telehealth: $20 copay; Virtual: No charge | Telehealth: 40% after deductible; Virtual: Not covered | Telehealth: $15 copay; Virtual: No charge | Telehealth: 50% after deductible; Virtual: Not covered |
| Specialist Visit | $20 copay | 40% after deductible | $15 copay | 50% after deductible |
| Lab & X– ray | Lab: No charge / 20%; X-ray: 20%; Imaging: 20% after deductible | X-ray and Imaging: 40% after deductible; Lab: Not covered | Lab: No charge / 20%; X-ray: 20%; Imaging: 20% after deductible | X-ray and Imaging: 50% after deductible; Lab: Not covered |
| Urgent Care | $50 copay | 40% after deductible | $15 copay | 50% after deductible |
| Emergency Room | $100 copay | | $100 copay | |
| Outpatient Services | 20% after deductible | 40% after deductible (up to $760 / day) | 20% after deductible | 50% after deductible (up to $760 / day) |
| Inpatient Services | 20% after deductible | 40% after deductible | 20% after deductible | 50% after deductible |
| Chiropractic (24 visits / year) | $20 copay | Not covered | $15 copay | Not covered |
| Acupuncture (20 visits / year) | $20 copay | Not covered | $15 copay | Not covered |
| Prescription Drugs: Retail (up to a 31-day supply) | | | | |
| Tier 1<br>Tier 2<br>Tier 3 | $10 copay<br>$35 copay<br>$70 copay | | $5 copay<br>$30 copay<br>$65 copay | |
| Prescription Drugs: Mail Order (up to a 90-day supply) | | | | |
| Tier 1<br>Tier 2<br>Tier 3 | $25 copay<br>$87.50 copay<br>$175 copay | Not covered | $12.50 copay<br>$75 copay<br>$162.50 copay | Not covered |

*This chart provides a brief overview of benefits and coverage. Refer to the detailed summary plan documents for questions about a specific procedure, service, or provider. In the event of a conflict, the official plan documents prevail.*

# KNOW WHERE TO GO FOR CARE

Sometimes it's easy to know when you should go to an emergency room (ER), such as when you have severe chest pain or a possible broken bone. At other times, it's less clear. Where do you go when you have an ear infection, or are generally not feeling well? You have choices for receiving in-network care that accommodate your schedule and give you access to the kind of care you need. Know when to use each for non-emergency treatment. The illustration below can help you decide where to go for different kinds of health concerns.

|  |  |  |  |  |
|---|---|---|---|---|
| Virtual Care | Retail Clinics | Your Doctor | Immediate/ Urgent Care | Emergency Room |
| Around the clock video or phone calls. | For medical care when you can't see your doctor | Your first choice for non-emergency care | When it's not a true emergency but needs immediate attention | Life-threatening problems that need immediate attention |
| Average Cost: $ | Average Cost: $ | Average Cost: $$ | Average Cost: $$$ | Average Cost: $$$$ |
| • Sore throat<br>• Headache<br>• Stomach ache<br>• Fever<br>• Cold and flu<br>• Allergies<br>• Rash<br>• Acne<br>• UTIs and more | • Infections<br>• Cold and flu<br>• Minor injuries/ pain<br>• Shots<br>• Skin problems<br>• Sore / strep throat<br>• Bronchitis<br>• Allergies | • Preventive Care<br>• Immunizations/ screenings<br>• Cuts / scrapes<br>• Eye swelling, pain<br>• Fever, colds, flu<br>• Sore throat<br>• Minor burns<br>• Stomach ache<br>• Ear / sinus pain<br>• Physicals<br>• Minor allergic reactions | • Earaches and infections<br>• Minor cuts, bumps, sprains, and burns<br>• Fever and flu symptoms<br>• Allergic reactions<br>• Animal bites<br>• Mild asthma<br>• Headaches<br>• UTIs<br>• Back and joint pain | • Chest pain, stroke<br>• Seizures<br>• Head or neck injuries<br>• Sudden or severe pain<br>• Heart attack<br>• Severe vomiting, diarrhea<br>• Fainting, dizziness, weakness<br>• Uncontrolled bleeding<br>• Problems breathing<br>• Broken bones |

| | | |
|---|---|---|
| Kaiser | 800-464-4000 | www.kp.org |
| United Healthcare | PPO Plans:<br>866-633-2446<br>HSA plan:<br>866-314-0335 | www.myuhc.com |

 No matter where you go for care, make sure you are using an in-network provider!

# HEALTH SAVINGS ACCOUNT (HSA)

If you enroll in the HDHP medical plan, you can set aside pre-tax dollars from your paycheck into a Health Savings Account (HSA) to help pay for your deductible and out-of-pocket health care expenses. The HSA provides you with more control over how you spend your health care dollars. This account is yours and goes with you, even if you leave Rimini Street.

## Eligibility

There are specific requirements to open and contribute to an HSA. It's important to identify your HSA eligibility status during your enrollment. You qualify if:

- You are enrolled in a qualified HDHP and have no other health coverage.
- You or your covered spouse do not participate in a Health Care Flexible Spending Account. (You are eligible to participate in the Limited Purpose FSA. See page 19 for details.)
- You are not enrolled in Medicare.
- You are not claimed as a dependent on someone else's tax return.

## Eligible Expenses

Some common eligible expenses may include:

- Medical deductibles and coinsurance
- Eligible prescriptions and over-the-counter medications
- Vision care, including LASIK laser eye surgery
- Dental care, including orthodontia

Review the IRS Publication 969 for more details on eligible expenses at https://www.irs.gov/publications/p969.

## Contributions

You can easily contribute out of your paycheck. But, as an added bonus, Rimini Street contributes to your HSA, too! The IRS does limit how much you can contribute to your HSA on an annual basis.

| Coverage Type | 2025 Rimini Street HSA Contribution | 2025 Maximum Employee Contribution | 2025 Maximum Contribution Limit |
|---|---|---|---|
| Individual | $1,500 | $2,800 | $4,300 |
| Family | $2,500 | $6,050 | $8,550 |
| Age 55+ | Additional $1,000 | | |

### Tax Savings

Don't miss out on tax savings by contributing to your HSA!

- Contributions are **tax-free**.
- Withdrawals for eligible health care expenses are **tax-free**.

## Opening Your Account

In 2025, Rimini will deposit up to $1,500 annually for individual coverage and up to $2,500 annually for family coverage. To ensure you receive the company contribution each year, you must select to participate in the HSA during open enrollment even if you choose 0.00 as a contribution amount. **NOTE:** If you are newly hired during the plan year, Rimini Street contributions are pro-rated based on your HSA effective date.

## Using Your HSA Funds

You will receive a Optum debit card to pay for eligible expenses. You can also submit claims online through your account at www.optumbank.com.

# DENTAL

With the PPO dental plan through MetLife, you may visit any dentist of your choice. Keep in mind, you'll receive the highest coverage when you use an in-network provider. If you visit and out-of-network provider, you will not benefit from discounted rates and will pay more out-of-pocket for services. Many dentist outside the provider network will require you to pay for services upfront and submit forms for reimbursement from your plan. For easy access, download the MetLife mobile app in the App Store on Google Play.

MetLife does not issue ID Cards. Your dental provider can verify your coverage for yourself and your dependents with the employee's social security number.

| | |
|---|---|
| DPPO | • In- and out-of-network coverage<br>• Visit any dentist you choose<br>• Must meet the deductible before the plan will start paying coinsurance<br>• In-network providers give you discounted rates and the highest level of coverage<br>• Out-of-network dentists may require you to pay for services upfront, submit forms for reimbursement from your plan, and may charge more for services |

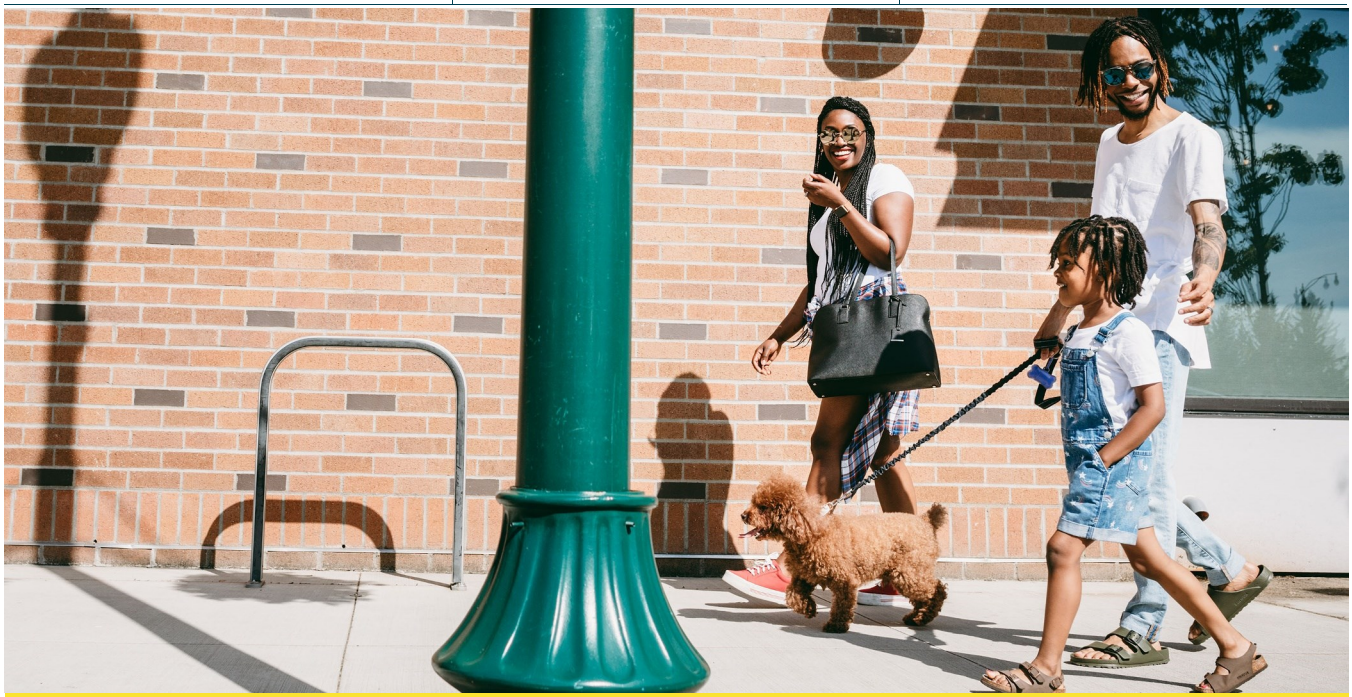
| Plan Features | MetLife Dental PPO Plan | | |
|---|---|---|---|
| | In-Network | Out-of-Network | Out-of-Network (TX, LA, and MT Only) Due to State Regulations |
| | You pay: | | |
| Calendar Year Deductible (waived for Preventive Services) | $50 Individual / $150 Family | | |
| Calendar Year Benefit Maximum | $2,500 | $1,500 | $2,500 |
| Type A - Preventive Services | Covered in full | 20% | Covered in full |
| Type B - Basic Restorative Services | 10% after deductible | 20% after deductible | 10% after deductible |
| Type C - Major Restorative Services | 30% after deductible | 50% after deductible | 30% after deductible |
| Type D - Orthodontia (children to age 26, adults) | 50% | 50% | 50% |
| Orthodontia Lifetime Maximum | $1,500 | | |

# VISION

Our comprehensive vision plan through VSP includes a national network of optometrists and vision care specialists and retail chains. Even though you can go outside of the VSP network, you'll receive the best benefits by staying in the network. Search providers anytime at www.vsp.com.

VSP does not issue ID cards. Your vision provider can verify your coverage for yourself and your dependents with the employee's social security number.

| Plan Features | VSP Vision | |
|---|---|---|
| | In-Network | Out-of-Network |
| | You Pay: | Plan reimburses you: |
| Exam every 12 months | $10 copay | Up to $50 |
| Frames every 12 months | $200 allowance plus 20% off on the amount due over your allowance | Up to $70 |
| **Lenses every 12 months** | | |
| Single Vision | $25 copay | Up to $50 |
| Bifocal | $25 copay | Up to $75 |
| Trifocal | $25 copay | Up to $100 |
| Lenticular | $25 copay | Up to $125 |
| **Contact Lenses (in lieu of lenses and frames) every 12 months** | | |
| Medically Necessary<br>Conventional | Covered in full after $25 copay<br>$200 allowance | Up to $210<br>Up to $105 |



# YOUR COST OF HEALTH CARE COVERAGE

Below is what will be deducted monthly for medical, dental, and vision coverage.

| Benefit Plan | Employee Only | Employee + Spouse /Domestic Partner* | Employee + Children | Employee + Family |
|---|---|---|---|---|
| **Medical** | | | | |
| Kaiser (CA only) | $0.00 | $481.87 | $401.56 | $876.13 |
| United Healthcare HDHP HSA | $0.00 | $376.85 | $194.74 | $782.55 |
| United Healthcare PPO 1500-80/50 | $0.00 | $538.15 | $325.44 | $1,022.06 |
| United Healthcare PPO 250-80/60 | $0.00 | $740.49 | $493.67 | $1,313.95 |
| **Dental** | | | | |
| MetLife Dental PPO | $0.00 | $20.27 | $25.89 | $45.11 |
| **Vision** | | | | |
| VSP Vision | $0.00 | $4.81 | $4.94 | $11.98 |

** Imputed income: Domestic partner contributions are taken on a post-tax basis. Contributions made by the employer for domestic partner coverage will be subject to imputed income for the employee.*

## How to Save Money on Health Care

| Get Your Free In-Network Preventive Care: | Use Mail Order Prescription Drug Program: | Take Advantage of 24/7 Access to Doctors: | Call the Nurse Line First: | Take Generic Medications: | Contribute to a Tax Savings Account: |
|---|---|---|---|---|---|
| Preventive health screenings keep you healthy throughout the year, monitor health risks, and catch any problems early. | Fill your maintenance medication to receive a 90-day supply of each prescription drug for the cost of a 60-day supply. | Use telehealth for minor medical issues from the comfort of your home. | Receive health advice any time of the day or night from experienced nurses. | Talk to your doctor about taking generic prescriptions, which are just as effective as brand-name drugs at a fraction of the cost. | Pay for health care and dependent care expenses with tax-free dollars with the Health Savings Account and Flexible Spending Accounts. |

# VOLUNTARY SUPPLEMENTAL HEALTH BENEFIT PLANS

**IMPORTANT: This is a fixed indemnity policy, NOT health insurance**

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

**Looking for comprehensive health insurance?**

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

**Questions about this policy?**

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Although Rimini Street medical plans provide great coverage for you and your family's general health care needs, everyone's needs are different. In addition to your other plan selections, you can elect these voluntary Voya benefits to protect your family's finances in case of an unforeseen injury, illness, or hospitalization.

Highlights of enrolling in these coverages include:

- Guaranteed issue, so there's no health questions asked (although certain medical conditions may not be covered)
- Payment of benefits is delivered directly to you
- You may elect coverage for yourself, your spouse/domestic partner, and your children

For all plan costs or to learn more, visit www.voya.com.

## Accident Insurance

Accident insurance pays you benefits for injuries resulting from a non-work-related accident, such as burns, lacerations, dislocations/fractures, and more. There's even a $100 wellness benefit per covered person if you receive certain preventive and wellness services during the year. Visit www.voya.com for the claim form and submission instructions.

## Critical Illness Insurance

If you are diagnosed with a serious health condition, such as a heart attack, coma, kidney failure, or cancer (just to name a few), you'll receive a lump sum direct payment. **Rates vary based on elected Benefit amount, age, and tobacco use.** There's even a $100 wellness benefit per covered person if you receive certain preventive and wellness services during the year. Visit www.voya.com for the claim form and submission instructions.

## Hospital Indemnity

Hospital Indemnity provides a cash payment if you are admitted to or treated at a hospital. Benefits are provided based on what type of hospital stay you have (e.g., ICU) and the number of days you are confined.

## Submitting a Claim

Submitting a claim is easy. You'll want to log in (or register) at www.voya.com. From there, you'll be able to submit your claim(s) electronically. It's the quickest and easiest way without worrying about printing forms.

# FLEXIBLE SPENDING ACCOUNTS (FSA)

Flexible Spending Accounts (FSAs) are administered by Navia. Health Care and Dependent Care FSA enables you to set aside money on a pre-tax basis to pay for out-of-pocket health and dependent care cost.

There are three types of accounts: The Health Care FSA, the Limited Purpose FSA, and the Dependent Care FSA. You can participate in FSA even if you are not enrolled in a medical plan. You can participate in the Limited Purpose FSA only if you chose the United Healthcare High Deductible Health Plan with HSA (HDHP) as your medical plan option.

Keep track of your FSAs by downloading MyNavia on the App Store or Google Play or by visiting www.naviabenefits.com.

To view eligible and ineligible expenses, please visit:

**Health Care FSA** https://www.naviabenefits.com/participants/resources/expenses/?benefit=health-care-fsa

**Limited Purpose FSA** https://www.naviabenefits.com/participants/resources/expenses/?benefit=limited-health-care

**Dependent Care FSA** https://www.naviabenefits.com/participants/resources/expenses/?benefit=day-care-fsa

| Plan Feature | Health Care FSA | Limited Purpose FSA | Dependent Care FSA |
|---|---|---|---|
| Eligibility | Employees NOT enrolled in our HDHP with HSA or any HDHP plan with HSA | Employees enrolled in the UHC HDHP with HSA | All employees |
| Annual Contribution Limit | $3,300 | 3,300 | $5,000 ($2,500 if married and filing separately) |
| Eligible Expenses* | Medical plan deductibles, copays, coinsurance, and prescriptions, including dental and vision expenses | Dental and vision expenses **only** | Daycare for children age 12 and under, disabled children, and tax-dependent adults |
| Availability of Funds | The full annual amount you elect is available on your plan effective date | The full annual amount you elect is available on your plan effective date | You can be reimbursed up to the amount available in your account |
| Payment or Reimbursement Options | Navia Debit card or reimbursement | Navia Debit card or reimbursement | Reimbursement |
| Rollover Options | Yes, you may rollover up to $660 of unused funds when you re-enroll | Yes, you may rollover up to $660 of unused funds when you re-enroll | Unused funds do not rollover |
| Deadline for Services | Services must be incurred by December 31, 2025 | Services must be incurred by December 31, 2025 | Services must be incurred by December 31, 2025 |
| Deadline for Submission for Reimbursement | Reimbursement must be submitted by March 31, 2026 | Reimbursement must be submitted by March 31, 2026 | Reimbursement must be submitted by March 31, 2026 |

**Refer to IRS Publication 502 (https://www.irs.gov/publications/p502) and 503 (https://www.irs.gov/publications/p503) for a complete list of eligible expenses.*

## Employee Assistance Program (EAP)

When you need help with work, home, personal, or family issues, the Employee Assistance Program (EAP) through TELUS Health offers helpful programs and services at no cost to you or your dependents.

**The TELUS Health EAP gives you access to:**

- Unlimited phone sessions
- Up to 5 face-to-face or virtual (where available) sessions per incident per year
- Mental health support for anxiety, depression, grief, and loss
- Work/life services, like creating goals, navigating work issues, family support, and more
- Childcare and elder care assistance
- Financial services assistance
- Legal resources
- Identity theft recovery services
- Concierge services

Contact the EAP confidentially anytime, day or night, by calling 888-267-8126, or by visiting https://rimini-street.lifeworks.com.

## Mental Health Matters

Did you know 1 in 5 will experience a mental illness in a given year? Your overall well-being is connected to your mental health, so here are some strategies to help you thrive year-round.

Create healthy routines. Healthy routines include eating a nutrient-rich diet, exercising and getting enough sleep. Start with small changes.

Own your feelings. It can be easy to get caught up in emotions as you're feeling them. Taking the time to identify what you're feeling can help you better cope with challenging situations.

Connect with others. Connections help enrich your life and power you through challenging times. Connect with and lean on your support group.

Cultivate gratitude. Practicing gratitude is linked to improved mental health. Consider keeping a gratitude journal, meditation or making a point to thank people in your life.

# LIFE AND AD&D INSURANCE

By offering life and disability benefit plans, we're helping you protect your finances in case of an unforeseen death or injury. Be sure to carefully review your options.

## Basic Life and AD&D Insurance

As an eligible employee, you receive both Basic Life and AD&D insurance equal to 2 times your annual earnings up to a maximum of $400,000. Coverage exceeding $50,000 is imputed income. This means the premium for any amount over $50,000 must be included as income and will be subject to Social Security and Medicare taxes, which may be reflected in your paycheck. There is no cost to you for Basic Life and AD&D coverage. It is automatically provided by Rimini Street.

## Voluntary Life and AD&D Insurance

For added financial protection, in addition to Basic Life and AD&D, you may elect Voluntary Life and AD&D coverage at discounted rates for you, your spouse/domestic partner, and your dependent children.

| Benefit Features | Voluntary Life and AD&D Options | | |
|---|---|---|---|
| | Employee | Spouse/Domestic Partner | Dependent Children (under age 26) |
| Coverage | 1 to 7 times your salary in $10,000 increments, to a maximum of $1,000,000 | Increments of $5,000 to a maximum of $250,000 (cannot exceed employee coverage) | Increments of $2,500 to a maximum of $10,000 (cannot exceed 50% of employee coverage) |
| Guaranteed Issue Amount (when first eligible) | $350,000 | $50,000 | $10,000 |
| Guaranteed Issue Period | Within 14 days from date of hire | | |
| Guaranteed Issue Amount (Open Enrollment / Family Status Change | **EMPLOYEE**: If you are an employee currently enrolled in voluntary life you can increase you coverage amount by $10,000 without providing evidence of insurability. Any amount higher will require you to submit evidence of insurability.<br><br>If you have been previously denied coverage, you will be required to submit evidence of insurability. If you voluntarily waive coverage, any amount selected in the future is subject to evidence of insurability (EOI).<br><br>**SPOUSE**: If you are an employee currently enrolled in voluntary life you can increase the coverage amount for your spouse or domestic partner by $5,000 without evidence of insurability. Any amount higher would require you to submit an evidence of insurability form.<br><br>If you have been previously denied coverage, you will be required to submit evidence of insurability (EOI). If you voluntarily waive coverage, any amount selected in the future is subject to evidence of insurability (EOI). | | |

| Voluntary Life Premiums | |
|---|---|
| Employee, Spouse/Domestic Partner | |
| Age | Monthly rate Per $1,000 of coverage |
| Under age 30 | $0.079 |
| 30-34 | $0.080 |
| 35-39 | $0.103 |
| 40-44 | $0.166 |
| 45-49 | $0.278 |
| 50-54 | $0.467 |
| 55-59 | $0.762 |
| 60-64 | $0.953 |
| 65-69 | $1.537 |
| 70 and Older | $3.057 |
| Optional Supplemental Children Life | $0.164 |
| Voluntary AD&D Premiums | |
| Optional Supplemental AD&D (Employee) | $0.014 |
| Optional Supplemental AD&D (Spouse) | $0.020 |
| Optional Supplemental AD&D (Child) | $0.010 |

## What is EOI?

Evidence of Insurability (EOI) is the process of providing health information to qualify for certain types of insurance coverage. If you elect coverage above the guaranteed issue amount, you will be required to submit a health questionnaire (in some cases, a physical exam may be required). Your questionnaire must be reviewed and approved by Lincoln Financial before coverage begins.

## Name Your Beneficiary

In case of your death or serious injury, it's important you've named a beneficiary. Review your designations anytime to ensure they are up to date and accurate. You may change your beneficiary as often as you wish at lfg.com.

# DISABILITY COVERAGE

## Short-Term Disability (STD)

Short-Term Disability through Lincoln Financial provides you with a portion of income replacement if you are unable to work due to a non-work related illness or injury. You are automatically enrolled in STD at no cost to you.

STD benefits may be offset by benefits you receive from a state-mandated disability plan, if applicable.

| Short-Term Disability (STD) | | | |
|---|---|---|---|
| Percent of Earnings | Weekly Maximum | Elimination Period (the time you wait until benefit begin) | Maximum Duration |
| 60% | $2,500 | 7 days | 13 weeks |

## Long-Term Disability (LTD)

Long-Term Disability through Lincoln Financial pays you a portion of your earnings if your condition keeps you out of work past the end of the STD benefit period. You are automatically enrolled in LTD at no cost to you.

Benefits are reduced by other sources of disability income you may qualify for, such as Social Security and Workers' Compensation.

| Long-Term Disability (LTD) | | | |
|---|---|---|---|
| Percent of Earnings | Monthly Maximum | Elimination Period | Maximum Duration |
| 60% | $10,000 | 90 days | Up to Social Security Normal Retirement Age or ADEA |

## 401(k) Plan

### 401(k) Highlights

- You may participate in the 401(k) plan on your first day of employment.
- You may enroll, select beneficiaries, and make changes to your plan any time throughout the year.
- Rimini Street will match 100% of each dollar you contribute up to the first 4% of your annual salary once you meet 6 months of service. Eligibility requirement for the employer match is effective January 1, 2025.

While you may elect to make contributions to both a traditional 401(k) and a Roth 401(k), the combined total cannot be more than $23,500 per year. If you're age 50 or over, you can make "catch up" contributions up to $7,500 per year.

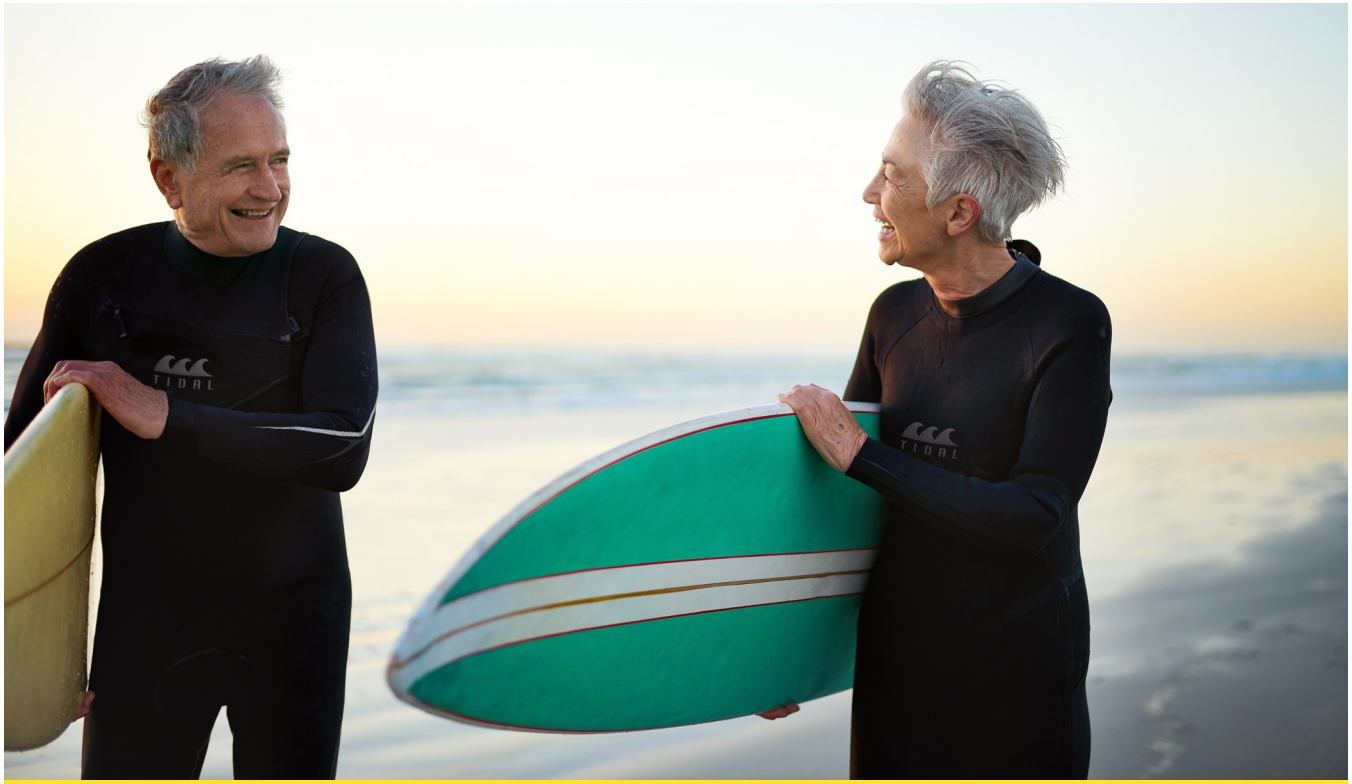
Keep track of your Fidelity 401(k):

Call (800) 343-3548

Online at www.netbenefits.com

### The Difference Between a Traditional & Roth 401(k)

| Traditional 401(k) | Roth 401(k) |
|---|---|
| Contributions are made before taxes are taken. You will pay taxes when you withdraw the money in retirement. | Contributions are made after taxes have been deducted. You pay taxes in the year you make them, but not when you withdraw the money in retirement. Funds grow tax-free. |



## Commuter Benefit Plan

Commuter Benefits are administered by Navia. These programs allow employees who commute to and from work to set aside pre-tax funds to pay for their work-related mass transit and parking expenses. Eligible expenses for the transit benefit include transit passes, fare cards, ticket books, and vanpool expenses.

You may deduct pre-tax money from your paycheck to pay for commute-related expenses, which reduces your taxable income. The maximum contribution is:

- Transit: $325 monthly
- Parking: $325 monthly

## Voluntary Pet Insurance

Veterinary bills can add up quickly. With Figo, you can save on unexpected veterinary expenses plus optional coverage to help pay for routine veterinary care, such as vaccines, well-being exams, and teeth cleaning.

Visit www.figopetinsurance.com to get an instant quote and enroll at any time. Call Figo at 844-738-3446 to speak with a pet insurance expert if you have any questions. For being a Rimini Street Employee, you will receive a 5% discount on Figo Pet Insurance.

## Paid Time Off Plan

Our PTO (Paid Time Off) plan is designed to provide eligible employees with paid time off for any reason, such as for vacation, personal time, or observance of religious holidays, personal illness, personal injury of dependents and/or family members.

Regular full–time employees, as well as regular part-time employees who are regularly scheduled to work 30 hours or more per week, accrue PTO based on the below chart.

All eligible US employees, excluding New Mexico and Washington, will have a maximum annual accrual cap of 1.5 times their annual accrual rate that will carry-over from year to year. Eligible employees will stop accruing PTO hours once they have reached their level cap, and will not begin to accrue PTO hours until the PTO balance falls below their respective cap. Refer to the below chart:

| Years of Service | Level | Annual Accrual Rate | Maximum Cap (1.5x) | Per Pay Period Accrual |
|---|---|---|---|---|
| 0-4 years | 1 | 15 days (120 hours) | 22.5 days (180 hours) | 5 hours |
| 5-9 years | 2 | 20 days (160 hours) | 30 days (240 hours) | 6.66 hours |
| 10 plus years | 3 | 25 days (200 hours) | 37.5 days (300 hours) | 8.33 hours |

For further details regarding the PTO policy for New Mexico and Washington employees, please refer to the respective state supplement.

# BENEFITS CONTACTS

| Coverage | Contact | Policy Number | Phone | Website |
|---|---|---|---|---|
| Medical | Kaiser Permanente | 603239 | 800-464-4000 | www.kp.org |
| | United Healthcare | 909202 | PPO Plans: 866-633-2446 HSA plan: 866-314-0335 | www.myuhc.com |
| Health Savings Account (HSA) | Optum Bank | 909202 | 800-791-9361 | www.optumbank.com |
| Dental | MetLife | 5386556 | 800-438-6388 | www.metlife.com |
| Vision | VSP | 30023839 | 800-877-7195 | www.vsp.com |
| Employee Assistance Program (EAP) | TELUS Health | Rimini Street | 888-267-8126 | https://rimini-street.lifeworks.com |
| Flexible Spending Account (FSA) | Navia | RMZ | 800-669-3539 | www.naviabenefits.com |
| Commuter Benefit | | | | |
| Life and AD&D | Lincoln Financial | 09-LF0793 | 800-423-2765 | www.lfg.com |
| Disability | | | | |
| 401(k) | Fidelity | 00820 | 800-890-4015 | www.netbenefits.com |
| Pet Insurance | Figo | Rimini Street | 844-738-3446 | www.figopetinsurance.com |
| Accident, Critical Illness, and Hospital Indemnity | Voya | 697877 | 800-955-7736 | www.voya.com |

If you have any questions, please reach out to the Rimini Street Benefits Team at benefits@riministreet.com.

**At the back of this guide you will find all of your Healthcare Annual Notices.**

**You can also find them posted on the Rimini Street Benefits portal under Notices and Documents**

| | |
|---|---|
| Women's Health & Cancer Rights Act (WHCRA) | Medicare Part D Notice |
| Patient Protection Notice | HIPAA Notice of Special Enrollment |
| Children's Health Insurance Program (CHIP) Notice | HIPAA Privacy Notice |

# Rimini Street, Inc. - Annual Notices

*Plan Year Effective:*
**1/1/2025**

# Women’s Health & Cancer Rights Act (WHCRA)

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 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 the medical plan.

Contact your Human Resources Department for more information.

# Patient Protection Notice

HMO plans generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. Until you make this designation, the HMO may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the carrier.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, 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 carrier.

# 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).**

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2024. Contact your State for more information on eligibility –**

| ALABAMA – Medicaid | ALASKA – Medicaid |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility:<br>https://health.alaska.gov/dpa/Pages/default.aspx |
| **ARKANSAS – Medicaid** | **CALIFORNIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Health Insurance Premium Payment (HIPP) Program Website:<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Fax: 916-440-5676<br>Email: hipp@dhcs.ca.gov |
| **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** | **FLORIDA – Medicaid** |
| Health First Colorado Website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center:<br>1-800-221-3943/State Relay 711<br>CHP+: https://hcpf.colorado.gov/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/State Relay 711<br>Health Insurance Buy-In Program (HIBI):<br>https://www.mycohibi.com/<br>HIBI Customer Service: 1-855-692-6442 | Website:<br>https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |
| **GEORGIA – Medicaid** | **INDIANA – Medicaid** |
| GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162, Press 1<br>GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra<br>Phone: 678-564-1162, Press 2 | Health Insurance Premium Payment Program<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>http://www.in.gov/fssa/dfr/<br>Family and Social Services Administration<br>Phone: 1-800-403-0864<br>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: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

**KENTUCKY – Medicaid**

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

**LOUISIANA – Medicaid**

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or
1-855-618-5488 (LaHIPP)

**MAINE – Medicaid**

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

**MASSACHUSETTS – Medicaid and CHIP**

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

**MINNESOTA – Medicaid**

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

**MISSOURI – Medicaid**

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

**MONTANA – Medicaid**

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

**NEBRASKA – Medicaid**

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

**NEVADA – Medicaid**

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

**NEW HAMPSHIRE – Medicaid**

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

**NEW JERSEY – Medicaid and CHIP**

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

**NEW YORK – Medicaid**

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

**NORTH CAROLINA – Medicaid**

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

**NORTH DAKOTA – Medicaid**

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

**OKLAHOMA – Medicaid and CHIP**

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

**OREGON – Medicaid and CHIP**

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

| PENNSYLVANIA – Medicaid and CHIP | RHODE ISLAND – Medicaid and CHIP |
|---|---|
| Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html<br>Phone: 1-800-692-7462<br>CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)<br>CHIP Phone: 1-800-986-KIDS (5437) | Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or<br>401-462-0311 (Direct RIte Share Line) |
| **SOUTH CAROLINA – Medicaid** | **SOUTH DAKOTA - Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 |
| **TEXAS – Medicaid** | **UTAH – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Texas Health and Human Services<br>Phone: 1-800-440-0493 | Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/<br>Email: upp@utah.gov<br>Phone: 1-888-222-2542<br>Adult Expansion Website: https://medicaid.utah.gov/expansion/<br>Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/<br>CHIP Website: https://chip.utah.gov/ |
| **VERMONT– Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website: Health Insurance Premium Payment (HIPP) Program \| Department of Vermont Health Access<br>Phone: 1-800-250-8427 | Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select<br>https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs<br>Medicaid/CHIP Phone: 1-800-432-5924 |
| **WASHINGTON – Medicaid** | **WEST VIRGINIA – Medicaid and CHIP** |
| Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 | Website: https://dhhr.wv.gov/bms/<br>http://mywvhipp.com/<br>Medicaid Phone: 304-558-1700<br>CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **WISCONSIN – Medicaid and CHIP** | **WYOMING – Medicaid** |
| Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2024, 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 1/31/2026)*

# Medicare Part D – Creditable Coverage

### Important Notice from Rimini Street, Inc. 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 Rimini Street, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Rimini Street, Inc. has determined that the prescription drug coverage offered by the Rimini Street Inc. Welfare Benefits Plan 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 - 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 coverage will be affected. For those individuals who elect Part D coverage, drug coverage under the Rimini Street Inc. Welfare Benefits Plan will end for the individual and all covered dependents.

If you do decide to join a Medicare drug plan and drop your current Rimini Street, Inc. coverage, be aware that you and your dependents will 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 Rimini Street, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

For further information, call Ines Fontanella at 984-359-9221. 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 Rimini Street, Inc. 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).**

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|---|---|
| Plan Year: | 1/1/2025 |
| Name of Entity/Sender: | Rimini Street, Inc. |
| Contact—Position/Office: | Ines Fontanella |
| Address: | 1700 S. Pavillion Center Dr., Suite 330, Las Vegas, NV 89135 |
| Phone Number: | 984-359-9221 |

MODEL INDIVIDUAL **CREDITABLE** COVERAGE DISCLOSURE NOTICE LANGUAGE OMB 0938-0990 FOR USE ON OR AFTER APRIL 1, 2011

# HIPAA Notice of Special Enrollment

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 and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward 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 a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Name: Ines Fontanella

Title: Sr. Manager, Global Benefits

Phone number: 984-359-9221

# Memo Regarding HIPAA Privacy Notice

## Rimini Street Inc. Welfare Benefits Plan

## Notice of Privacy Practices

## For The Use and Disclosure of Protected Health Information (PHI)

**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

The Rimini Street Inc. Welfare Benefits Plan is required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices with respect to PHI. PHI is information that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices (Notice) describes how we may use and disclose PHI to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. This Notice also describes your rights with respect to PHI about you.

The Plan is required to follow the terms of this Notice. We will not use or disclose PHI about you without your written authorization, except as described in this Notice. We reserve the right to change our practices and this Notice, and to make the new Notice effective for all PHI we maintain. Upon request, we will provide any revised Notice to you.

### Notice of PHI Uses and Disclosures

#### Required PHI Uses and Disclosures.

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

#### Uses and Disclosures To Carry Out Treatment, Payment, And Health Care Operations.

The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan also will disclose PHI to Rimini Street, Inc. for purposes related to treatment, payment and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

**Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

**Payment** includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

**Health care operations** include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes.

## Uses And Disclosures That Require Your Written Authorization.

Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed by the Plan to defend against litigation filed by you. In addition, your written authorization will be obtained for uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI.

## Uses And Disclosures That Require That You Be Given An Opportunity To Agree Or Disagree Prior To The Use Or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and,
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

## Uses And Disclosures For Which Consent, Authorization Or Opportunity To Object Is Not Required.

Use and disclosure of your PHI is allowed without your consent, authorization or request under the following circumstances:

1. When required by law.

2. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

3. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose or reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. When required for law enforcement purposes (for example, to report certain types of wounds).

7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Covered Entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

9. The Plan may use or disclose PHI for research, subject to conditions.

10. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

## Rights of Individuals

### Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operation, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Such requests should be made to the following officer: Ines Fontanella, Sr. Manager, Global Benefits, 984-359-9221, 1700 S. Pavillion Center Dr., Suite 330Las Vegas, NV 89135. Email - ifontanella@riministreet.com

Note, however, that a covered entity (generally, a health care provider) must agree to your request to restrict the disclosure of your PHI to a health plan for any health care or operations purpose that relates to a health care item or service that you have paid in full out-of-pocket, or paid in full by a third party (other than a health plan) on your behalf.

### Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set”, for as long as the plan maintains the PHI.

· **Protected Health Information** (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

· **Designated Records Set** includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the Covered Entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made to the following officer: Ines Fontanella, Sr. Manager, Global Benefits, 984-359-9221, 1700 S. Pavillion Center Dr., Suite 330, Las Vegas, NV 89135. Email - ifontanella@riministreet.com

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of U.S. Department of Health and Human Services.

### Right to Amend PHI

You have the right to request the plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Requests for amendment of PHI in a designated record set should be made to the following officer: Ines Fontanella, Sr. Manager, Global Benefits.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

### The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made:

1. to carry out treatment, payment or health care operations;
2. to individuals about their own PHI
3. prior to the compliance date; or,

4. based on your written authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

### The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice contact the following officer: Ines Fontanella, Sr. Manager, Global Benefits.

### The Right to Be Notified of a Breach of Unsecured PHI

The Plan is required by law to notify you following a breach of any Unsecured PHI.

### The Right to Opt-Out of Fundraising Communications

If we conduct fundraising and we use communications like the U.S. Postal Service or electronic email for fundraising, you have the right to opt-out of receiving such communications from us. Please contact Ines Fontanella, Sr. Manager, Global Benefits, to opt-out of fundraising communications if you chose to do so.

### A Note about Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual; or,
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

## The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices.

This notice is effective beginning 01/01/2025 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided (to all past and present participants and beneficiaries) for whom the Plan still maintains PHI.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

### Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another Covered Entity, the plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and,
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

In addition, the Plan may use or disclose “summary health information” to the plan sponsor for obtaining premium bids or modifying, amending or terminating the Group Health Plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Group Health Plan; and from which identifying information has been deleted in accordance with HIPAA.

## Your Right To File A Complaint With The Plan Or The HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan in care of the following officer: Ines Fontanella, Sr. Manager, Global Benefits, 984-359-9221, 1700 S. Pavillion Center Dr., Suite 330, Las Vegas, NV 89135. Email - ifontanella@riministreet.com

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

## Whom to Contact For More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer: Ines Fontanella, Sr. Manager, Global Benefits, 984-359-9221, 1700 S. Pavillion Center Dr., Suite 330, Las Vegas, NV 89135. Email - ifontanella@riministreet.com


Rimini Street®