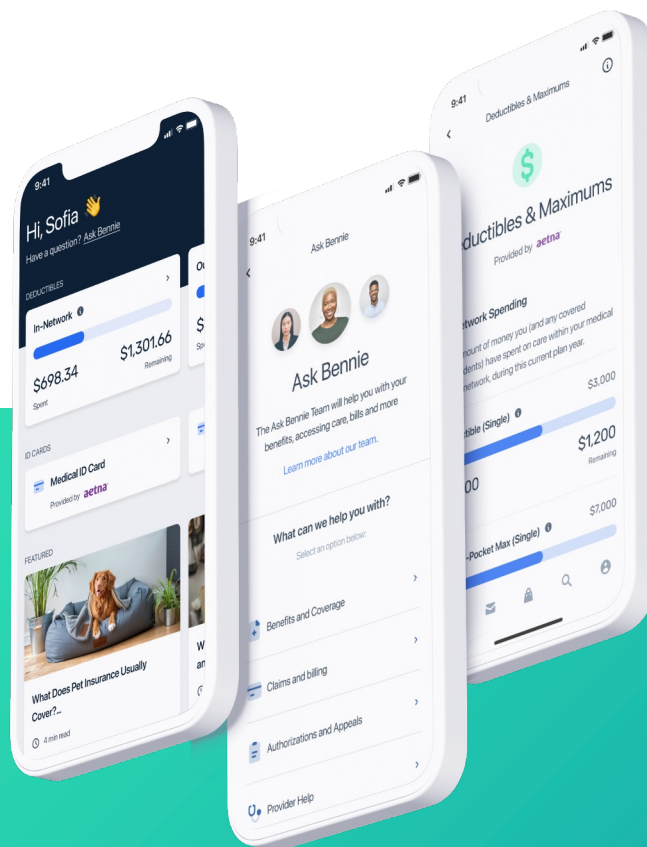


# ramp

## Benefits Guide

January 1, 2026 – December 31, 2026



Benefits Brought to You By

**Bennie** BETTER BENEFITS

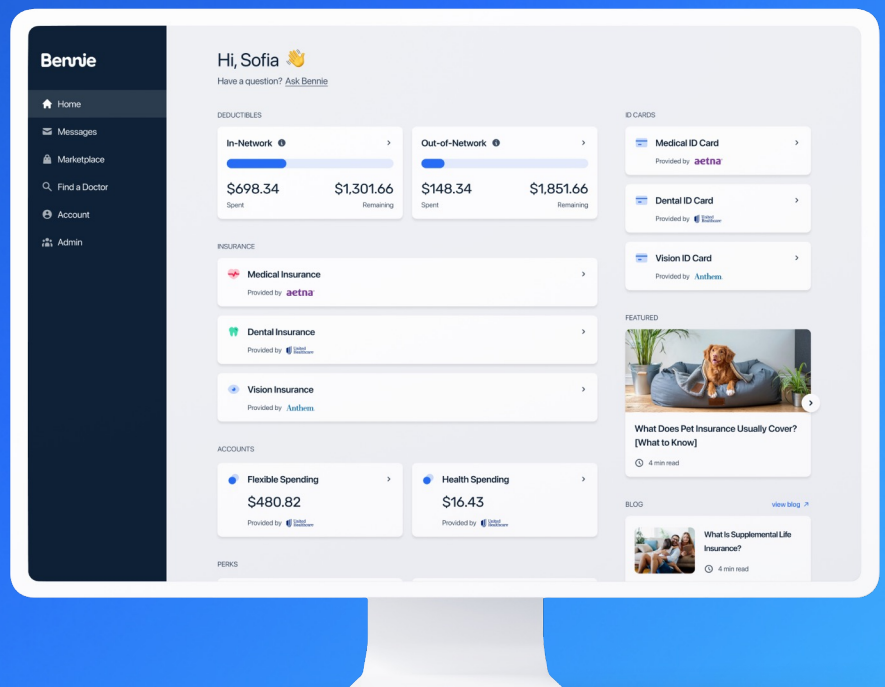
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## Section 1

# Introduction



## Dear Valued Employees,

This Benefits Guide summarizes the Ramp Business Corporation employee benefits options available for the period of January 1, 2026 through December 31, 2026. Please review the guide carefully so you can choose plans that best fit the needs of you and your family.

### Open Enrollment:

Open enrollment is your annual opportunity to enroll in health benefits. During this time, you can also transfer to a different plan and add eligible family members. After you've enrolled, it is recommended to print or save your confirmation statement and to review this statement to ensure all information is correct.

### New Employees & Newly Eligible Employees:

If you are a new employee or a newly eligible employee, you must actively enroll if you want to receive benefits through any of these plans. You must complete enrollment no later than 30 days after your hire date or the date of your change in eligibility status. After this date, you will not be able to make any changes to your coverage until the next open enrollment.



**You must complete your online enrollment by:**

**12/2/25**



**If you have questions or need more information, please contact:**

**HR Team:**  
People Team

**By Email:**  
[people@ramp.com](mailto:people@ramp.com)

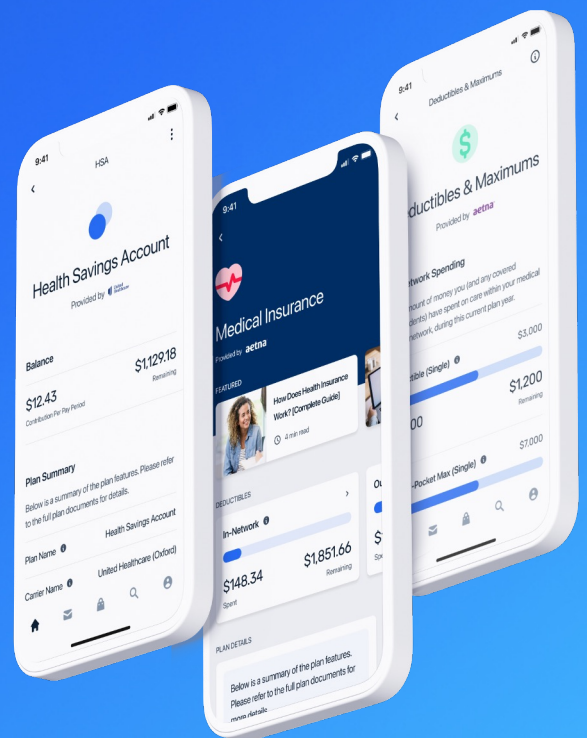
Sincerely,

**ramp** 



## Section 2

# Eligibility Requirements & Deadlines





## Initial Eligibility



### Who is Eligible for Health Benefits?

Employees who work a minimum of 30 hours per week are eligible for health benefits as described in this booklet.



### When Do Benefits Become Effective?

For newly hired or newly-eligible employees, benefits begin on your date of hire.



### What are the Enrollment Deadlines?

For newly hired employees or for those who become newly eligible during the plan year, you must enroll no later than 30 days after your date of hire or the date of your change in eligibility status.



### Can I Cover my Dependents?

Your legal spouse, domestic partner, and/or legal children are eligible as dependents on the company's benefit plans.



### Termination Provisions

If you are no longer employed by **Ramp Business Corporation**, your medical, dental, and vision benefits end at the end of the month you last worked. For life and disability, benefits end on the day of termination. For additional information on continuing your coverage under COBRA, please reference your COBRA rights in the notices section of this document.



## Ongoing Eligibility & Maintenance



### Making Changes to Your Health Benefits

Once you make benefit elections during open enrollment, you will not have another opportunity to make a change to your health benefits until the next open enrollment unless you experience a change in status, otherwise known as a “qualifying event.”



### What is a Qualifying Event?

- Marriage, Divorce or legal separation
- Birth or adoption of a child
- A change in your or your spouse’s employment or insurance status
- A dependent ceasing to meet eligibility requirements
- A change in residence that affects coverage
- Gain or loss of Medicare coverage

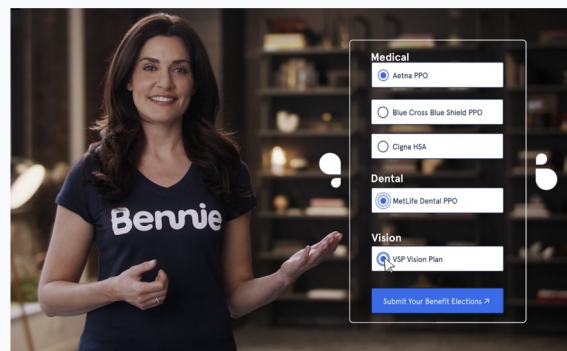


### Qualifying Event Deadlines

Should you experience a qualifying event and need to make a change in your coverage, you must log into your benefits administration platform within 30 days of the event and complete the appropriate submission. If you fail to submit your request within 30 days of the event, you will not be able to make a change and will be required to wait until the next open enrollment or another qualifying event, whichever comes first.

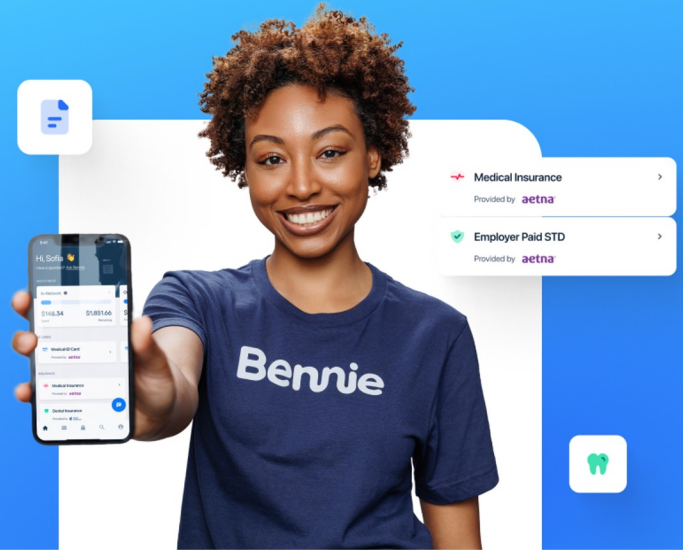
**New to Bennie?**  
Here’s what to expect next.

[WATCH VIDEO](#)



# Better Benefits

Bennie partners with your HR team to offer a single hub for all employee benefits information as well as an on-demand healthcare concierge.

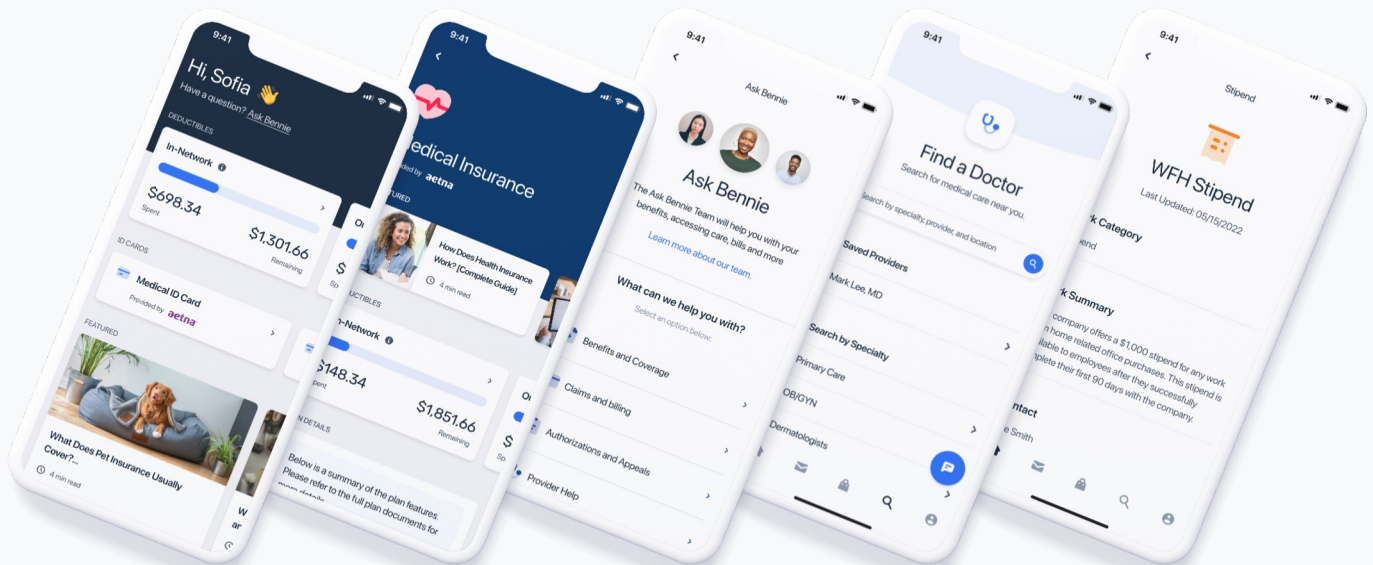


## About Bennie

Whenever you have a question about your benefits, the Bennie app is there to help you get the answers you need and resolve any issues.

In addition to the benefits provided through your company, Bennie's individual marketplace allows you to access personalized benefits that meet your unique needs.

Download the Bennie App today!



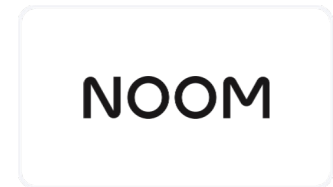
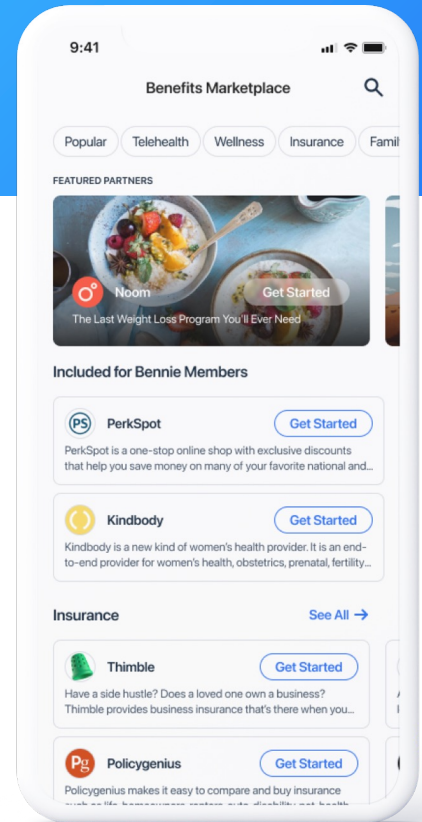
# Benefits Marketplace For Health & Wellbeing

## Our Mission

To provide everyone with access to better benefits and help create a healthier world.

## Access a Variety of Additional Benefits

The Bennie Marketplace includes physical, social, financial, and emotional benefits from leading wellness providers. You can enroll with a Bennie marketplace partner at any time! There's no need to involve your HR team as you sign up for these services directly with the vendor. Simply log in to your Bennie App and click on the Marketplace tab to start exploring.



## For Employees

### Individual Voluntary Benefits

You can choose wellness benefits to suit your specific needs.

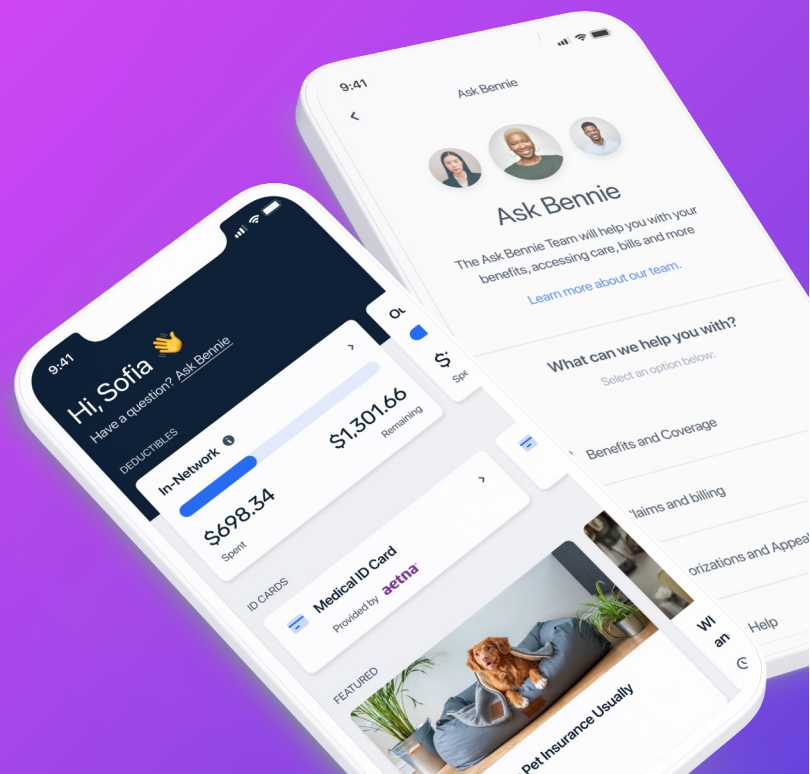
- Pet Insurance
- Financial Advice
- Mental Health Support
- Family Planning
- Caregiving Support
- And More





## Section 3

# Ask Bennie



# Ask Bennie Office Hours | 9 AM - 7 PM ET Monday - Friday

## A Unified Experience

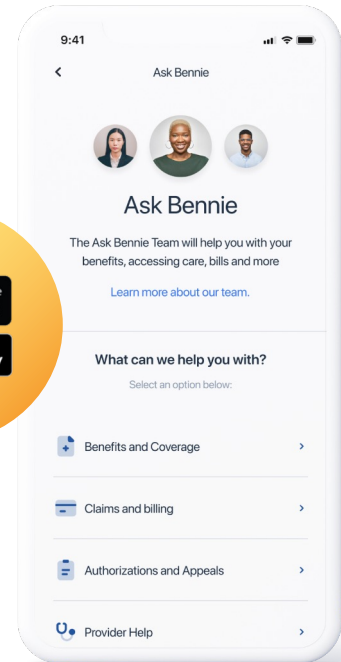
### The Complete Package

With Ask Bennie, you can speak with expert Advocates who can help you understand your benefits, find doctors, fix billing mistakes, book appointments, and more.

## Accessible Advocates

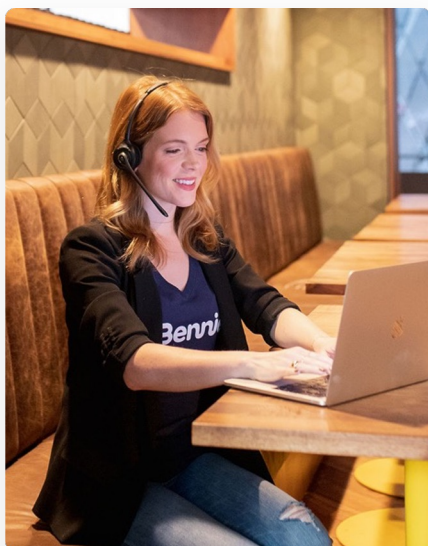
### White Glove Service

Ask Bennie Advocates are experts in healthcare, who work for you—not the insurance company. With Ask Bennie, you can get help with your benefits or healthcare questions at any time.



## The Help You Need, When You Need It

Delivered in a modern experience through the Bennie mobile app.



### Benefits Questions

Get quick answers regarding benefits. You will be notified as soon as the Ask Bennie team replies.



### Enrollment Support

Expert support during your open enrollment process. Bennie can help you compare cost and benefit details, so you can choose the right plan for you and your family.



### Billing Review

Got a confusing medical bill? The Bennie team can review it for you, ensuring it's accurate.



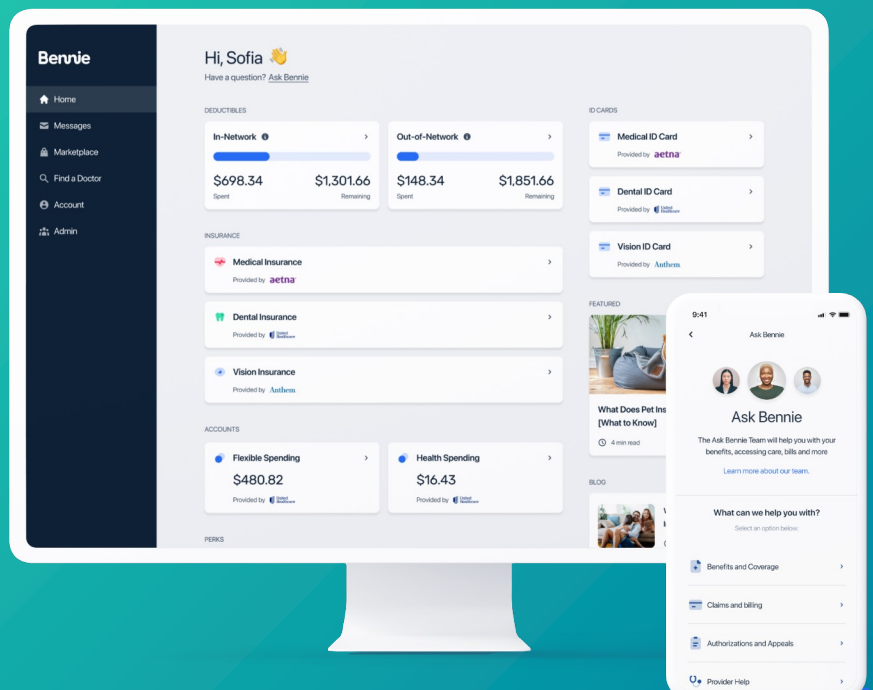
### Find a Provider

Find low cost, high quality providers with the touch of a button. Bennie provides the best matches in your area.



## Section 4

# Your 2026 Benefits





## Navigating Your Benefits

Below are some helpful tips on how to utilize and best navigate your benefits.

### Tips on Utilizing Your Benefits

- 1** Always stay in-network whenever possible
- 2** Take advantage of preventive care – it's free!
- 3** Use urgent care centers and mini-clinics instead of emergency rooms when not a true emergency
- 4** Use telemedicine to save time and money
- 5** Ask about the costs of services & prescriptions before receiving them
- 6** Use online resources:  
FSAsStore.com, HSAsStore.com, GoodRx.com, CostPlusDrugs.com and more



# Medical: In-Network

**Member ID Cards**



If you elect benefits, find out when you can expect your member ID cards.

Your medical and prescription drug coverage is offered through Cigna. Ramp Business Corporation provides comprehensive medical and prescription drug coverage through three plan options. The below is a high-level comparison between the plan options. For full plan details, please refer to the medical plan summaries available for download in PlanSource and / or Bennie App.

To search for providers, visit the Bennie app or visit the carrier website [here](#).



	HDHP Plan	OAP PPO Plan	OAPIN EPO Plan
<b>Company HSA Funding</b>	<b>\$1,800 / \$2,700</b>	<b>N/A</b>	<b>N/A</b>
<b>In-Network</b>	<i>Open Access Plus</i>	<i>Open Access Plus</i>	<i>Open Access Plus</i>
<b>Deductible</b> <i>Based on Plan Year</i>	\$2,500 / \$5,000 <i>Embedded</i>	\$500 / \$1,500 <i>Embedded</i>	\$0 <i>Embedded</i>
<b>Coinsurance</b>	0%	20%	0%
<b>Out-of-Pocket Maximum</b> <i>Individual / Family</i> <i>(includes deductible, coinsurance &amp; copays)</i>	\$3,425 / \$6,850	\$3,500 / \$7,000	\$3,000 / \$6,000
<b>Preventative Care</b>	Covered 100%	Covered 100%	Covered 100%
<b>Primary Care Copay</b>	0% after deductible	\$20 copay	\$30 copay
<b>Specialist Copay</b>	0% after deductible	\$20 copay	\$40 copay
<b>X-Rays &amp; Labs / Advanced Imaging</b>	0% after deductible/ \$100 scan per day	20% after deductible / \$100 scan per day	\$100 copay
<b>Telehealth Visits</b>	0% after deductible	\$20 copay	\$30 copay
<b>Urgent Care</b>	0% after deductible	\$20 copay	\$40 copay
<b>Emergency Room</b>	0% after deductible	\$150 copay	\$150 copay
<b>Inpatient Hospital Services</b>	0% after deductible	20% after deductible	\$500 per admission
<b>Outpatient Hospital Services</b>	0% after deductible	20% after deductible	No Charge
<b>Prescription Deductible</b>	Tied with Medical	N/A	N/A
<b>Prescription Copay (Retail)</b> <i>Tier 1 / Tier 2 / Tier 3 / Specialty</i>	\$10 / \$30 / \$50 after deductible	\$10 / \$20 / \$40	\$10 / \$20 / \$40



# Medical: Out-of-Network

Your medical and prescription drug coverage is offered through Cigna. Ramp Business Corporation provides comprehensive medical and prescription drug coverage through three plan options. The below is a high-level comparison between the plan options. For full plan details, please refer to the medical plan summaries available for download in PlanSource and / or Bennie App.



	HDHP Plan	OAP PPO Plan	OAPIN EPO Plan
<b>Company HSA Funding</b>	\$1,800 / \$2,700	N/A	N/A
<b>Out-of-Network</b>			
<b>Deductible</b> <i>Based on Plan Year</i>	\$2,500 / \$5,000 <i>Embedded</i>	\$1,000 / \$3,000 <i>Embedded</i>	Not Covered
<b>Coinsurance</b>	30%	30%	Not Covered
<b>Out-of-Pocket Maximum</b> <i>Individual / Family</i> <i>(includes deductible, coinsurance &amp; copays)</i>	\$7,000 / \$14,000	\$7,000 / \$14,000	Not Covered
<b>Preventative Care</b>	30% after deductible	30% after deductible	Not Covered
<b>Primary Care Copay</b>	30% after deductible	30% after deductible	Not Covered
<b>Specialist Copay</b>	30% after deductible	30% after deductible	Not Covered
<b>X-Rays / Labs / Advanced Imaging</b>	\$100 / 30%	40% after deductible/ \$100 scan per day	Not Covered
<b>Telehealth Visits</b>	30% after deductible	30% after deductible	
<b>Urgent Care</b>	30% after deductible	\$40 copay	Not Covered
<b>Emergency Room</b>	0% after deductible	\$150 copay	\$150 copay
<b>Inpatient Hospital Services</b>	30% after deductible	40% after deductible	Not Covered
<b>Outpatient Hospital Services</b>	30% after deductible	40% after deductible	Not Covered
<b>Prescription Deductible</b>	Not Covered	Not Covered	Not Covered
<b>Prescription Copay (Retail)</b> <i>Tier 1 / Tier 2 / Tier 3 / Specialty</i>	Not Covered	Not Covered	Not Covered



## FAQ: Medical Plan Questions



### What is considered preventive care?

Preventive care services are those that are completed by a doctor in your network to help prevent or detect medical issues before they become acute. Most health plans must cover a set of healthcare services that are free to you when delivered by a doctor or other provider in your plan's network. Services that are considered preventive care typically include annual physicals and well visits (child and women), vaccinations, and routine screenings (e.g. mammograms, colonoscopies).



### How do I know if I need a referral to see a specialist?

If your member ID card states "referrals required". You will need a referral from your primary care provider before seeking services from another Network provider or your care may not be covered.



### What is prior authorization?

Prior authorization means getting approval before you can get access to medication or services. With prior authorization, your health plan agrees to help pay for the service but this is subject to any cost sharing or other limitations may apply



### What does usual, customary, and reasonable (UCR) mean?

UCR refers to the usual, customary, and reasonable fees that providers, health care facilities or other health care professionals in the same geographical area charge for similar services. Plans that pay 100% of UCR or R&C pay 100% of the usual, customary, and reasonable fees for that service. If providers have an affiliation with the plan, they are obligated to accept the plan's UCR or R&C as payment in full. However, if providers are not affiliated with the plan, they are not obligated to accept the URC or R&C, and you may have to pay any charges in excess of the payment made by the plan.



# Telemedicine

On demand access to affordable, quality health care – anytime, anywhere.



**Cigna via their partner, MDLive, now offers another alternative to receive care. Visit with a US Board Certified doctor right from your home, office, or on the go for non-emergency medical conditions.**

## When to Use Telemedicine

- 24/7/365
- If your primary care doctor is not available
- Instead of going to the ER or an urgent care center (for a non-emergency issue)
- To request prescription refills\*
- If traveling and in need of medical care

## Common Conditions Treated

- |                  |                                      |
|------------------|--------------------------------------|
| • Allergies      | • Infections                         |
| • Asthma         | • Insect Bites                       |
| • Bronchitis     | • Joint Aches                        |
| • Cold & Flu     | • Rashes                             |
| • Diarrhea       | • Sinus Infections                   |
| • Ear Infections | • Skin Infections                    |
| • Fever          | • Sore Throat                        |
| • Headache       | • Specific Pediatric Care Conditions |
|                  | • And More                           |

**If you are enrolled in Cigna plan, telemedicine is available at the below costs:**

- HDHP Plan: 0% after deductible**
- OAP PPO Plan: \$20 copay**
- OAPIN EPO Plan: \$30-\$40 copay**

**Visit the [Bennie app](#) or [MDLive](#) to schedule a telemedicine visit today!**



## How to Decide Where to Go for Care

If you're not experiencing an emergency, being informed about where to go for medical care can result in time and cost savings. You have options for getting non-emergency medical attention.

The info below can assist you in determining the appropriate type of care for different situations. Opting for In-Network providers for your family's medical needs typically leads to reduced expenses.

**Is your condition possibly life threatening?**  
(e.g. heart attack, chest pain, major trauma)

**YES:** Go to the **Emergency Room (\$\$\$)**.

**NO:**

**Does your condition require immediate in-person attention?**  
(e.g. allergic reaction, minor injury)

**YES:** Go to **Urgent Care (\$\$)**.

**NO:**

**Is your PCP closed and you are comfortable with immediate remote care?** (e.g. sore throat, cold, primary care)

**YES:** Schedule a **Virtual Visit (\$)**.

**NO:**

**Is this for routine or preventive care that does not require immediate attention?** (e.g. preventive care, headaches)

**YES:** Go to your **Doctor's Office (\$)**.



## Health Savings Account (HSA)

PLANSOURCE

If you enroll in the high-deductible medical plan, you are eligible to open a Health Savings Account through PlanSource.

Ramp Business Corporation will contribute money into a Health Savings Account (HSA) on your behalf. You may also contribute additional money into this HSA.

- **Tax-free contributions:** Contributions to an HSA are made with pre-tax dollars, so they reduce your taxable income.
- **Money rolls over year to year:** Unlike some Flexible Spending Accounts (FSAs), the money in your HSA does not expire at the end of the year. You can rollover any unused funds to use in the future.
- **Can be used for a variety of qualified medical expenses:** HSAs can be used to pay for qualified medical, dental, and vision expenses, including deductibles, copays, and prescriptions. You can also use them to save for future health expenses. Visit [HSAStore.com](https://www.HSAStore.com) for additional eligible items.
- **Maximum Annual contributions are shown below:**

2026 HSA Contribution Limits		
	Single	Family
<b>Ramp Business Corporation Annual Contribution</b>	\$1,800	\$2,700
<b>Employee Annual Contribution</b>	\$2,600	\$6,050
<b>Combined Total Annual Contribution Limit</b>	\$4,400	\$8,750
<b>Catch-Up Contribution Limit (Ages 55 and Older)</b>	Additional \$1,000	Additional \$1,000

**⚠ The HSA is available only for enrollees in the following plans:**

- **HDHP Plan**

The IRS does not allow contributions to an HSA and a full-purpose FSA in the same tax year. If you have any money in a full-purpose FSA, you must spend it before you can contribute or receive any contributions into your HSA.



## Frequently Asked Questions about Health Savings Accounts (HSAs)

Eligibility	Contributions	Using HSA funds	Other
<p><b>Who can open an HSA?</b></p> <p>You can open an HSA if you are enrolled in an HSA-qualified High-Deductible Health Plan (HDHP). You cannot be covered by any other health insurance that isn't an HDHP, be enrolled in Medicare, or be claimed as a dependent on someone else's tax return.</p>	<p><b>How much money can I contribute to my HSA?</b></p> <p>The IRS sets annual contribution limits. In 2026, the maximum for self-only coverage is \$4,400 and \$8,750 for family coverage. If you are 55 or older, you can contribute an additional \$1,000 per year (catch-up contribution).</p>	<p><b>What can I use my HSA funds for?</b></p> <p>You can use your HSA funds to pay for qualified medical, dental, and vision expenses for yourself, your spouse, and your qualified dependents. You can find a full list of qualified expenses on the <a href="#">IRS website</a>.</p>	<p><b>What happens to the money in my HSA if I change jobs?</b></p> <p>The money in your HSA remains yours, even if you change jobs. You can continue to contribute to the account only if you are still enrolled in an HSA-qualified HDHP.</p>
<p><b>Can I have an HSA and a Flexible Spending Account (FSA) at the same time?</b></p> <p>Generally, no. You cannot contribute to both an HSA and an FSA in the same year if both accounts are used for qualified medical expenses.</p>	<p><b>Can anyone contribute to my HSA?</b></p> <p>Yes! Your employer may contribute to your HSA, and anyone can make a gift contribution to your account (up to the annual limit).</p>	<p><b>Can I use my HSA for premiums?</b></p> <p>You cannot use your HSA funds to pay for health insurance premiums.</p>	<p><b>Do my HSA funds earn interest?</b></p> <p>Yes, some HSAs offer interest-bearing accounts. Consult with your HSA provider for more information.</p>
<p><b>Can I have an HSA and a Limited Purpose FSA at the same time?</b></p> <p>Yes, you can have an HSA alongside a Limited-Purpose FSA (LPFSA). An LPFSA allows you to set aside pre-tax dollars to pay for <b>specific qualified expenses</b>, such as dental and vision expenses, while reserving your HSA funds for medical expenses</p>	<p><b>How can I contribute to my HSA?</b></p> <p>Contributions can be made through payroll deductions if offered by your employer, direct bank transfers, or check deposits.</p>	<p><b>How do I keep track of qualified expenses?</b></p> <p>It's important to maintain good records of qualified medical expenses. Save receipts and explanations of benefits (EOBs) from your insurance company.</p>	<p><b>What happens to my HSA if I don't use all the funds by the end of the year?</b></p> <p>Unlike FSAs, funds in your HSA rollover year to year. You can accumulate funds for future medical expenses.</p>



# Flexible Spending Account (FSA) PLANSOURCE

## 💰 Healthcare FSA

- **Can contribute to if you are not enrolled in the HSA plan.**
- FSA Contributions are tax-free, and funds become available on your effective date.
- Funds expire at the end of the year, so it is useful only if you have predictable expenses
- Can be used on qualifying medical, dental, and vision expenses (deductibles, copays, prescriptions). Visit [FSAstore.com](https://www.fsastore.com) for more eligible items.
- Can roll over the 2026 limit of up to **\$680** to the next plan year. (2027)
- Has a 90-day run-out period for filing claims from the previous year.
- **Maximum annual contribution is \$3,400 in 2026.**

## 🚩 Limited Purpose FSA

- Can contribute to if you enroll in the HDHP plan.
- FSA Contributions are tax-free, and funds become available on your effective date.
- Funds expire at the end of the year, so it is useful only if you have predictable expenses
- Can be used on qualifying **dental and vision expenses only**
- Can roll over the 2026 limit of up to **\$680** to the next plan year. (2027)
- Has a 90-day run-out period for filing claims from the previous year.
- **Maximum annual contribution is \$3,400 in 2026.**

## 💓 Dependent-Care FSA

- FSA Contributions are tax-free, and funds accrue with each pay period.
- Funds expire at the end of the year, so it is useful only if you have predictable expenses. The IRS does not permit remaining funds to be carried over into the next plan year.
- Can be used on qualifying dependent care expenses (day care, childcare, elder care) for dependent children up to age 13 or a disabled spouse/dependent needing care.
- **Cannot roll over any funds into the next plan year.**
- Has a 2.5-month grace period for submitting existing and new claims for the year
- **Maximum annual contribution is \$7,500 (in 2026) for single taxpayers or those married and filing jointly, and \$3,750 if married and filing separately.**

## ⚠️ Important to Know!

- **FSA Funds expire at the end of the plan year and must be actively elected each year.**
- **The IRS does not allow contributions to an HSA and a Healthcare FSA in the same tax year.**

It is important to budget carefully so as not to lose access to your contributed tax-free funds.



## Frequently Asked Questions about Healthcare Flexible Spending Accounts (FSAs) and Limited Purpose FSAs (LFSA).

### Healthcare FSA

#### Can I have an FSA if I'm covered by a Health Savings Account (HSA)?

No, you cannot participate in both an FSA and an HSA in the same year.

#### What is a Rollover?

- This is less common than a grace period and not all employers offer it.
- A rollover allows you to move a certain amount of your unused FSA funds into the next plan year.
- There may be a limit on how much can be rolled over, such as the IRS carryover amount (\$680 in 2026).
- **Unlike a grace period, you can use rollover funds for expenses incurred during the previous plan year.** This provides more flexibility in using your FSA funds.

#### Can I change my contribution amount during the year?

Typically, no. You'll set your contribution amount during your employer's open enrollment period.

#### How do I know if an expense is eligible?

Your employer's plan documents or benefits administrator should have a list of qualified expenses. You can also find general information online from sources like the IRS <https://www.irs.gov/forms-pubs/about-publication-969>.

### Limited Purpose FSA

#### Can I have an LFSA and an HSA?

Yes, you can have both an LFSA and an HSA in the same year, but the LFSA will have limitations on what expenses are qualified. You cannot have an FSA and an LFSA in the same tax year.

#### What can I use my LFSA funds for?

Unlike regular FSAs, LFSAs typically only cover certain expenses, such as dental care or vision care.



## Frequently Asked Questions about Dependent Care FSAs (DCFSA)

### Dependent Care FSA

#### Can my spouse and I both contribute to a DCFSA?

Yes, if you are married filing jointly, you can each elect to contribute to a DCFSA for a total combined limit.

**Married Filing Jointly:** The maximum contribution is \$7,500 per year in 2025. This means you and your spouse can contribute a combined total of up to \$7,500 to a DCFSA. You can choose to split it however you want, such as contributing the entire amount yourself or splitting it evenly.

**Single or Head of Household:** The maximum contribution limit is also \$7,500 per year for single filers and heads of household.

**Married Filing Separately:** In this case, the maximum contribution limit is \$3,750 per year. This applies to each spouse individually, not a combined amount.

#### How do I submit a claim for DCFSA reimbursement?

You'll typically file a claim electronically or by mail with a completed form and receipts for your expenses. Check with your FSA administrator for specific instructions.

#### Are there any limitations on how I can use my DCFSA funds?

Yes, the care provider must be licensed, and the expenses must be used to allow you and/or your spouse to work. Expenses for overnight camps generally are not eligible unless the camp has a significant educational component. [Click here](#) for a list of eligible expenses.

#### What is a Grace Period?

- Some employers offer a grace period as an extension of the plan year.
- This grace period allows you to use your remaining DCFSA funds for qualified medical expenses incurred during the grace period.
- The grace period cannot exceed 2.5 months after the plan year ends (typically by March 15th of the following year).
- **You cannot use the grace period for expenses incurred before the official plan year ended.** For example, if you have an expense in December but don't submit the claim until March, it likely won't be covered unless your plan offers a rollover option (see below). **However**, if your DCFSA plan has a runout period (typically 30, 60 or 90 days), this clause does allow you to submit claims incurred in the prior year plan through the runout period after the plan year ends.



# Health Reimbursement Account (HRA)



forma

Ramp provides the Ramp HRA Fertility designed to support employees to grow their families, by offering support for reproductive services through Forma.

## What is a Fertility HRA?

- **Employer-Funded Benefit:** Your employer contributions funds to reimburse you for qualified fertility expenses
- **Use it or Lose It:** Funds typically cannot be carried over to the next year
- **Submit Claims::** Submit reimbursement claims through the Forma website
- **Eligible Expenses:** Check your plan documents for a complete list of eligible expenses

## Why are HRAs helpful?

- **Tax Free Reimbursements:** Amounts reimbursed are not considered taxable income
- **Offer Lower Cost Healthcare:** You can use HRAs to be reimbursed for qualified medical expenses that health insurance doesn't pay for (e.g., deductibles, copays, out of pocket costs)

### Health Reimbursement Account Contributions

	Single	Lifetime Maximum
Ramp HRA Contributions	\$10,000	\$30,000

For the full details on the benefit, scan this QR code or visit your Forma portal.



### Important to Know!

**Note:** The reimbursements for in-network and out-of-network services are for Fertility based services only! Please check your plan documents for a list of eligible expenses.

Additionally, if you are on the HDHP plan, you must hit your deductible before your HRA can cover your fertility expenses.

# Dental



Dental insurance is provided through Cigna. Ramp Business Corporation offers a comprehensive dental plan. For full plan details, please refer to the dental plan summaries available for download in PlanSource and / or Bennie App.

To find a dental provider, visit [www.cigna.com](http://www.cigna.com)



## Dental PPO

The dental PPO option allows you to see a wide range of both in-network and out-of-network dentists and pays a reimbursement percentage based on the type of service you receive.

	Base Plan		Buy Up Plan	
	In-Network	Out-Of-Network	In-Network	Out-Of-Network
<b>Deductible</b>	\$50 / \$150	\$50 / \$150	\$50 / \$150	\$50 / \$150
<b>Dental Annual Maximum</b>	Year 1: \$1,500 Year 2: \$1,600 Year 3: \$1,700 Year 4+: \$1,800		Year 1: \$5,000 Year 2: \$5,100 Year 3: \$5,200 Year 4+: \$5,300	
<b>Preventative Care</b>	100% Covered	100% Covered	100% Covered	100% Covered
<b>Basic Services</b>	90% Covered	80% Covered	90% Covered	80% Covered
<b>Major Services</b>	60% Covered	50% Covered	60% Covered	50% Covered
<b>Orthodontic Lifetime Maximum</b>	Not Covered		\$2,000	
<b>Orthodontic Services <i>Adult &amp; Children</i></b>	Not Covered	Not Covered	50% Covered	50% Covered

### Considerations when using your dental plan:

- The dental annual maximum is the total amount that a dental plan will pay for a covered person's dental care within a 12-month period, which is also known as the benefit period. The annual maximum resets at the beginning of each new benefit period.
- Before undergoing major dental procedures, ask your dentist for a predetermination. This will provide an estimated cost breakdown of what your insurance will cover and your out-of-pocket expenses, allowing you to budget accordingly and make informed financial decisions.

### Important to Know!

**Note:** The reimbursements for in-network and out-of-network services may seem identical, but out-of-network providers may impose higher fees and "balance bill" after insurance payments, so it is generally more cost-effective to use in-network providers.

 **Vision**



Vision Insurance is provided through Cigna. Through this plan, you can access the Cigna Vision network of providers. For full plan details, please refer to the summaries available for download in PlanSource and / or Bennie App.

To locate a vision provider, visit [www.cigna.com](http://www.cigna.com)

Cigna Vision Network	In-Network	Frequency	Out-Of-Network (Reimbursement)
Exams	\$10 Copay	Every 12 months	Up to \$45
Materials	\$25 Copay	Every 12 months	Up to \$65
Frames	\$180 Allowance	Every 12 months	Up to \$100
Contacts	\$180 Allowance	Every 12 months	Up to \$144

**Considerations when using your vision plan:**

- **Service Date:** The 12-month period typically starts from the date of your last covered vision service, such as an eye exam or purchasing glasses. This means your benefits "reset" after a year from that date.
- Vision insurance typically excludes medical eye treatments like LASIK surgery or the treatment of eye diseases.

 **Important to Know!**

**Note:** This plan covers some out-of-network costs, with reimbursements based on an allowance determined by the type of service.



## Group & Voluntary Life and AD&D



**Group Life and Voluntary Life and AD&D Insurance is provided through New York Life. For full plan details, please refer to the plan summaries available for download in Paylocity and / or your Bennie App.**



### Group Life & Accidental Death and Dismemberment

- If you die, your beneficiary is entitled to receive 1x your annual earnings up to a maximum of \$500,000.
- If your death is the result of an accident, the accidental death and dismemberment benefit pays your beneficiary an additional 1x annual earning up to a maximum of \$500,000.
- This plan includes a provision for age-related benefit reduction. The benefit decreases by 65% at age 65, 50% at age 70.
- This benefit is offered by Ramp at no cost to you.



### Voluntary Life & AD&D

- Employee Benefit: Maximum \$500,000 in \$10,000 increments, \$300,000 Guaranteed issue (for newly hired employees)
- Spouse Benefit: Maximum \$250,000 in \$5,000 increments, \$25,000 Guaranteed issue (for newly hired employees)
- Child Benefit: Maximum of \$10,000 in \$1,000 increments.
- Employees must be enrolled in this benefit to enroll a Spouse and/or Child(ren)
- Coverage amounts increased at Open Enrollment may require Evidence of Insurability.
- Election of this benefit is voluntary and 100% employee-paid.

### Important to Know!

**Make sure your beneficiary information is up to date to ensure your loved ones receive the death benefit without delay or legal complications, providing them with crucial financial assistance during a difficult time.**

You can update it at any time in PlanSource.



# Disability



**Short-Term and Long-Term Disability Insurance is provided through New York Life. For full plan details, please refer to the plan summaries available for download in PlanSource and / or Bennie App.**

## Short-Term Disability

- If you become disabled as the result of an off-the-job accident, sickness, or condition, and remain disabled for over a week (on the 8th day for accidents and on the 8th day for sickness), you become eligible to receive short-term disability benefits.
- This benefit pays you 60% of your weekly earnings up to a maximum of \$3,500 per week. (For up to 13 weeks).
- This benefit is offered by Ramp Business Corporation at no cost to you.

## Long-Term Disability

- If you remain disabled after 90 days on short-term disability, you become eligible to receive long-term disability benefits.
- This benefit pays you 60% of your pre-disability monthly earnings, up to a maximum of \$15,000 per month.
- This disability plan includes a pre-existing condition provision.
- This benefit is offered by Ramp Business Corporation at no cost to you.

**Note:** If you have been diagnosed with or treated for a condition within the 3 months immediately prior to becoming covered by the plan (including pregnancy), you are ineligible to receive benefits for disabilities related to or caused by that condition for the first 12 months of coverage.



## Commuter

PLANSOURCE

If you use mass transit to get to and from work, you can contribute pre-tax money into an account through PlanSource to purchase your bus, train, or ferry pass.

There are two separate accounts available: one for commuting expenses and one for parking expenses.

### Mass Transit

- Set aside up to \$340 pre-tax monthly to help pay for commuting costs.
- Can be used for metro, trains, ridesharing, ferry etc.
- Contributions can be changed monthly.
- **Maximum annual contribution is \$4,080 in 2026.**

### Parking

- Set aside up to \$340 pre-tax monthly to help pay for qualified parking expenses.
- Qualified parking expenses include charges for parking at or near your place of work or a location from which you commute to work.
- Contributions can be changed monthly.
- **Maximum annual contribution is \$4,080 in 2026.**

### Important to Know!

Commuter funds rollover at the end of the plan year and remain active for the duration of your employment.



## Mental Health Resources

Strong mental health is key to a thriving you! It impacts your mood, focus, and ability to handle stress. By taking care of your mental well-being, you'll feel better equipped to tackle work challenges, maintain healthy relationships, and enjoy life to its fullest.

### Feeling overwhelmed? You're not alone.

A mental health crisis can strike anyone, at any time. It's a situation where your emotions or behaviors make it hard to cope with daily life.

### Here are some signs you might be in crisis:

- Intense feelings of sadness, anger, or anxiety
- Thoughts of harming yourself or others
- Difficulty functioning at work, school, or home
- Withdrawal from loved ones
- Increased substance abuse
- Changes in eating or sleeping habits

### If you're experiencing these signs, help is available. Here are some resources:

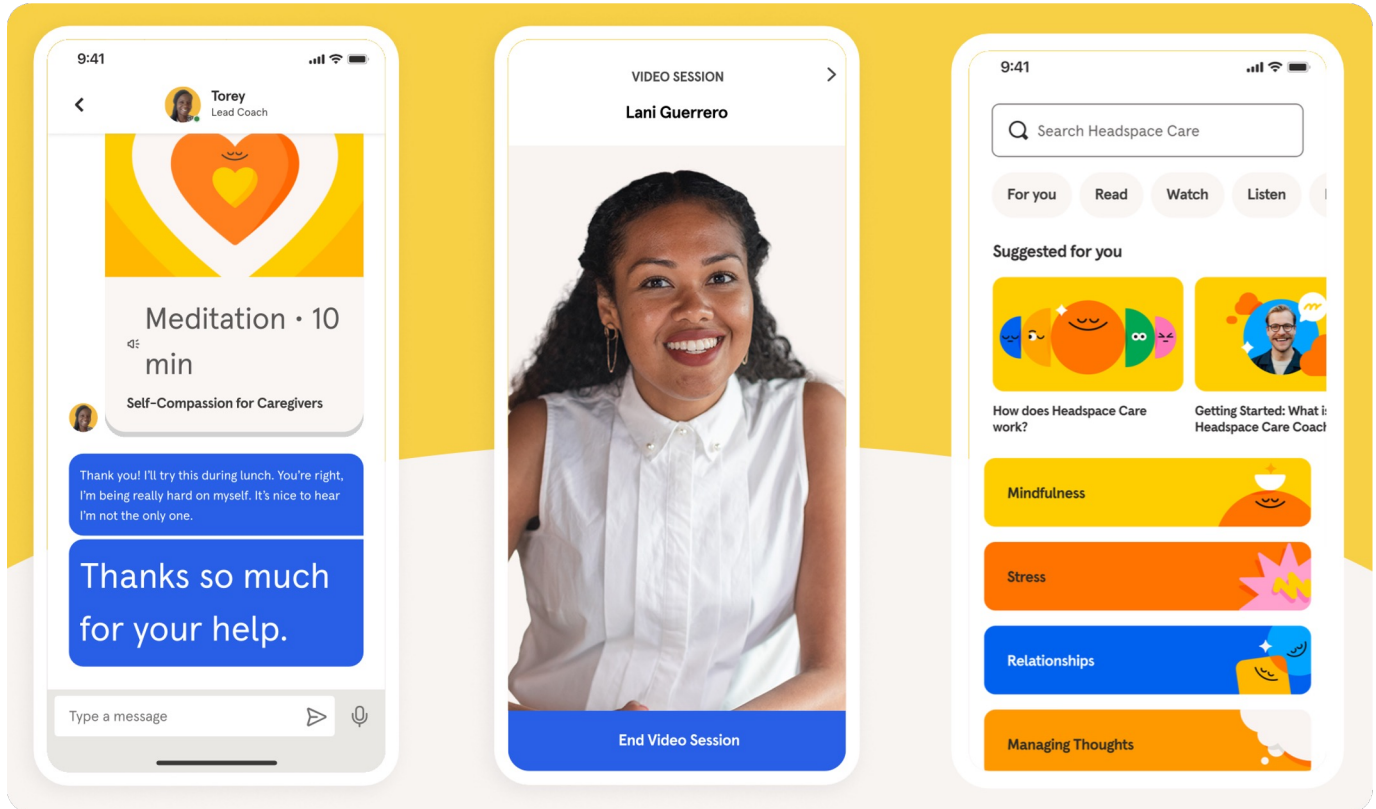
- **National Suicide Prevention Lifeline:** 988 (US)
- **Crisis Text Line:** Text HOME to 741741 (US)
- **The Trevor Project:** 1-866-488-7386 (LGBTQ youth)
- **The Jed Foundation:** <https://jedfoundation.org/> (mental health resources for teens and young adults)
- **National Alliance on Mental Illness (NAMI):** <https://www.nami.org/> (support, education, and advocacy)

**Remember, reaching out for help is a sign of strength. You don't have to go through this alone.**

# Headspace Care



Ramp through the partnership with Cigna’s plans, provides all benefits eligible employees with access to Headspace Care. Headspace Care provides on-demand mental health support for all of life’s challenges.



## Coaching

Connect with a coach via text-based chat to receive personalized support for whatever you are going through.

## Therapy & Psychiatry\*

A licensed therapist or psychiatrist can be added to your care team if you need extra support. These sessions are video-based and available evenings and weekends to fit your schedule.

## Skill-building resources

Our library of tips, tools, and insights includes articles, classes, and podcasts offering expert guidance on a range of topics. This in-app content is available for you to use in your own time to help you move toward your goals.



**Ready to get started?**  
Download the Headspace Care app and create an account.



One Medical



Ramp Corporation also provides all benefits eligible employees with access to One Medical. One Medical is a membership-based primary care practice on a mission to make getting quality care more affordable, accessible, and enjoyable for all through a blend of human-centered design, technology, and an exceptional team.

**A few reasons why people love One Medical**



**Same/next-day appointments that start on time**

Talk to an available provider of your choice about any health topic — from prevention to mental health to sexual health to chronic conditions — in an office or over video at a set time.\*



**24/7 care with Video Chat — at no cost to you**

Get care for urgent issues (like a stomach bug or rash) over Video Chat in minutes or message our medical team with our app anytime, day or night. There’s no cost to you — and it could potentially save you an unnecessary trip to the ER or urgent care.



**Access to offices nationwide**

Get exceptional care and drop-in lab work at beautiful offices designed to put you at ease — whether you’re at home or traveling.

\*In-office and Remote Visits are billed to insurance. Standard copay and deductibles apply. Check with your insurance for details. Remote Visits must be done with a provider in the state you’re currently in.



Download the One Medical app to easily book appointments, request prescriptions, get care 24/7, message providers, view your care plan, and more.

**Activate your sponsored membership today**

The cost of membership is covered for you, your spouse/partner, and dependents.

Sign up now at [onemedical.com/bennie](https://onemedical.com/bennie)  
Activation Code : BENHXOM





Ramp Corporation also provides all benefits eligible employees with access to Wellhub. Wellhub partners with the best gyms, studios, and wellbeing apps to give you convenient ways to take care of your health.

One simple subscription provides access to:



Over **10,000** gyms, studios, and live classes



**30+** wellbeing apps, covering topics such as nutrition, meditation, sleep, healthy habits, and more

### Specific gyms are available in different Wellhub plans.

There are many plan options, all designed to accommodate your budget and wellness needs. To see what's offered in each plan and view the entire network of gym partners, get started today.

- Download the Wellhub app, or go to [wellhub.com/en-us](https://wellhub.com/en-us)
- Create your free account
- Choose the plan that best fits you

[Create Your Free Account](#)

kindbody

## Fertility and family-building benefits

In partnership with Bennie, you have access to fertility and family-building benefits through Kindbody. Whether you want to start a family now, preserve your options for the future, or simply focus on your reproductive health and wellbeing – Kindbody is here for you.

Kindbody provides end-to-end fertility services with a dedicated care navigation team to guide you through your journey and coordinate the full spectrum of benefits available to you.

### Your Kindbody benefit includes:

- 20% discount\* off all services at Kindbody Signature Clinics
- Access to Kindbody's full suite of fertility and family-building services including IVF, IUI, and egg, embryo, and sperm freezing\*\*
- Fertility medications through Kindbody Rx\*\*
- Dedicated Care Navigation Team
- Live & virtual events
- A personalized patient portal



### How to get started with Kindbody:

- Head to <https://kindbody.com/activate/>
- Create your Kindbody account using any email address
- Confirm eligibility by entering your access code **(KINDBENNIE)** and your Unique ID which is your first name + last name + date of birth (example: marysmith511980).

For any questions or more information, email [employeebenefits@kindbody.com](mailto:employeebenefits@kindbody.com)

\*Current Kindbody pricing may vary. Visit [kindbody.com/pricing](https://kindbody.com/pricing) for details.

\*\*Medical and pharmacy services may be covered by Major Medical and subject to deductible, copays, or coinsurance as outlined by your health plan. You should verify that the Kindbody clinic is in network with your Medical insurance plan.



**One-stop-shop for thousands of exclusive discounts**



## What is the Bennie Discount Program with PerkSpot?

The Bennie Discount Program is a one-stop-shop for thousands of exclusive discounts in more than 25 different categories.

## How to Navigate Your Discount Program

### Perks Near You

This new feature allows you to use your location to see all nearby discounts, wherever you are! Discounts can be filtered by category and distance.

### Personalized Savings

You can inform us of your interests so we can feature the perks you're most interested in on your Discount Program Home Page.

### Brands Fit For Every Lifestyle

Searching for something specific? You can find the Brands page in the Popular Perks section, offering a simple and efficient way to browse all available discounts.

### Opportunities to Add Businesses

If you can't find what you're looking for, you can head to the Suggest a Business page to suggest your favorite brand and local spots be added to your Discount Program.

### Dedicated Support

PerkSpot's customer support team is here to help with any questions. You can find contact information below!

**If you have questions or need more information, please contact:**

#### Hours

Monday – Friday  
8:00 AM – 6:00 PM CST

#### Phone Number

(866) 606 - 6057

#### Email

cs@perkspot.com

#### Help Center

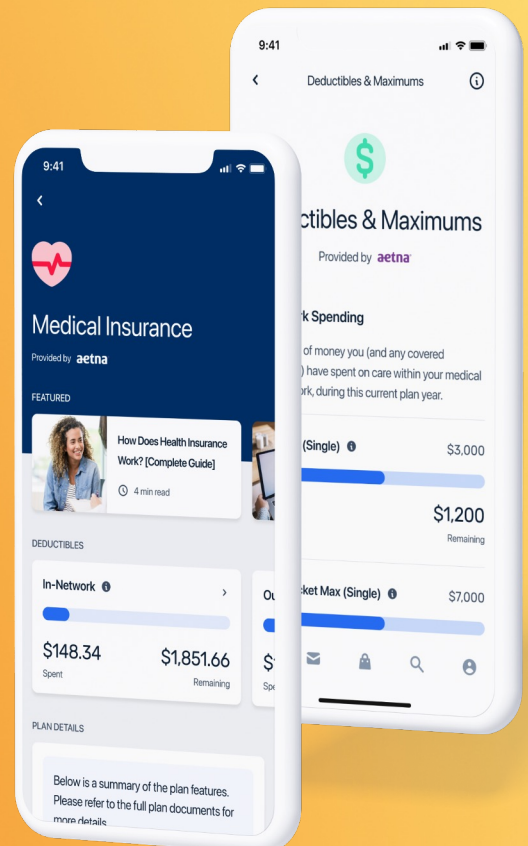
support.perkspot.com

**Ready to save? Visit [bennie.perkspot.com](https://bennie.perkspot.com) to get started!**



## Section 5

# Plan Costs



# Plan Costs

Below is a summary of the monthly costs per benefit provided by Ramp Business Corporation.

## Medical, Dental, Vision

HDHP Plan	Employee Monthly Cost
Employee	\$0.00
Employee + Spouse	\$291.27
Employee + Child(ren)	\$275.37
Employee + Family	\$413.02

Dental Base Plan	Employee Monthly Cost
Employee	\$0.00
Employee + Spouse	\$14.93
Employee + Child(ren)	\$17.75
Employee + Family	\$25.20

OAP PPO Plan	Employee Monthly Cost
Employee	\$0.00
Employee + Spouse	\$360.76
Employee + Child(ren)	\$341.24
Employee + Family	\$510.20

Dental Buy-Up Plan	Employee Monthly Cost
Employee	\$0.00
Employee + Spouse	\$24.68
Employee + Child(ren)	\$29.35
Employee + Family	\$41.66

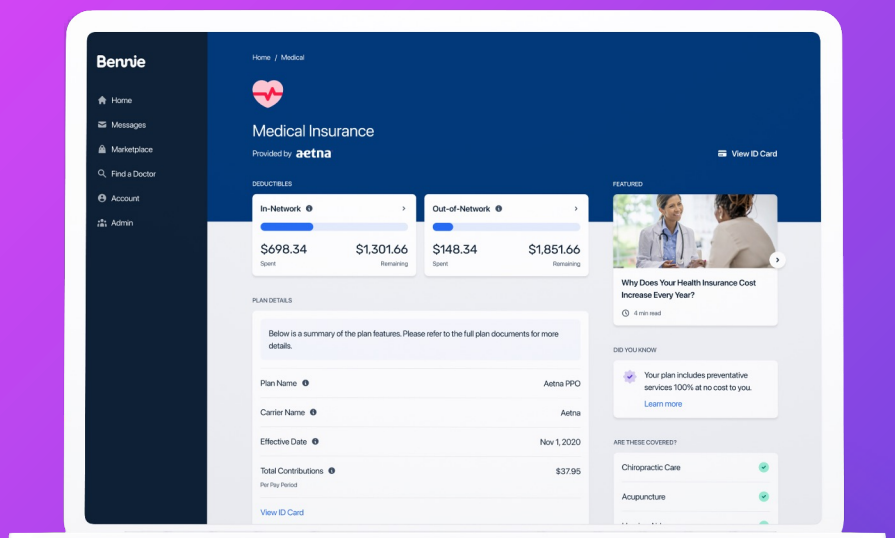
OAPIN EPO Plan	Employee Monthly Cost
Employee	\$0.00
Employee + Spouse	\$373.06
Employee + Child(ren)	\$352.87
Employee + Family	\$527.61

Vision Plan	Employee Monthly Cost
Employee	\$0.00
Employee + Spouse	\$2.28
Employee + Child(ren)	\$2.32
Employee + Family	\$3.74



## Section 6

# Benefits Enrollment





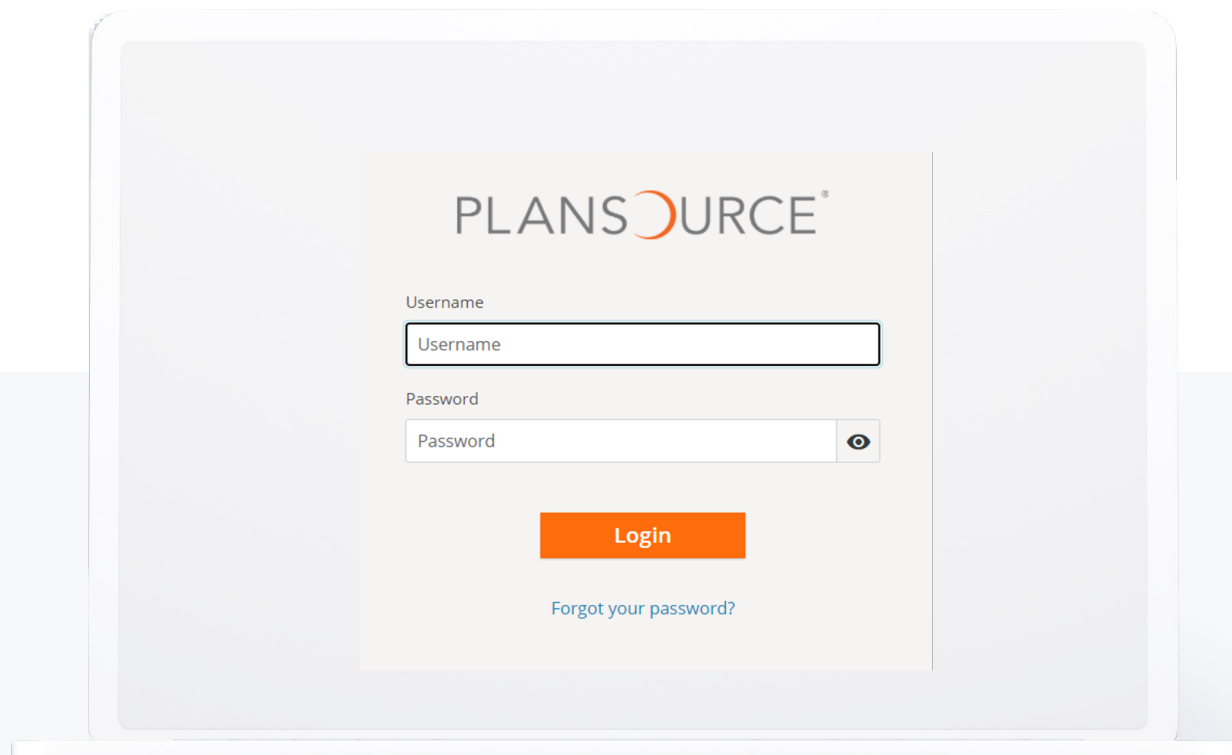
## Benefits Enrollment

Enroll in your benefits on the PlanSource platform.

# PLANSOURCE

**Login to elect or waive benefits for yourself and any dependents.**

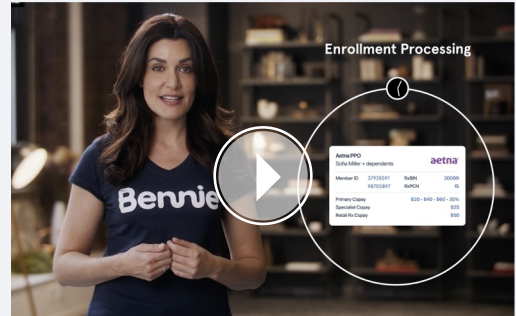
- Rates are displayed at the time of enrollment, so you know exactly how much will be taken out of your paycheck.
- You can also download plan documents for detailed plan information.



# You've made your elections, now what?

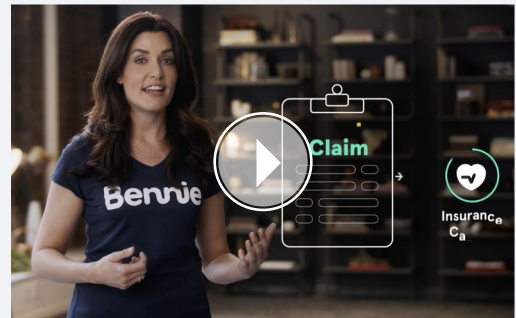
## When can I expect my ID Numbers & Physical ID Cards

[WATCH VIDEO](#)



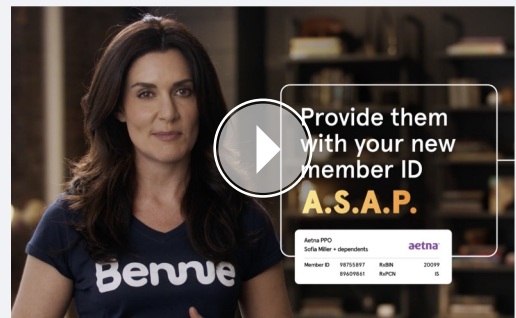
## Seeing a Provider or Filing a Claim Before Your Enrollment Has Processed

[WATCH VIDEO](#)



## What Should I Do If I Already Have a Procedure or Visit Scheduled?

[WATCH VIDEO](#)



**\*\*To prevent loading errors, please close video tabs prior to viewing subsequent videos.**

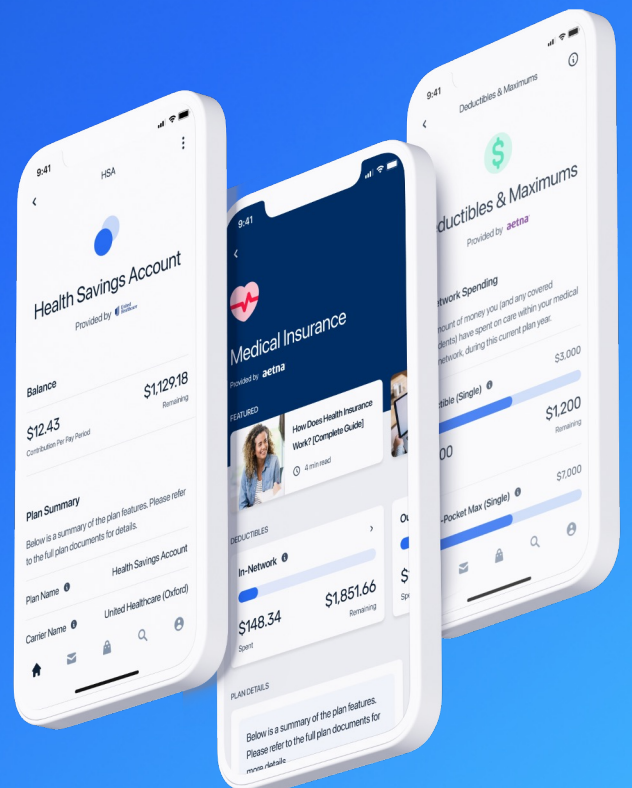
If you need additional assistance or need more clarification on what to expect after enrollment, feel free to contact our Ask Bennie team:

[Askbennie@bennie.com](mailto:Askbennie@bennie.com) | 844-905-3157



## Section 7

# Glossary





# Glossary of Terms

## Plan Coverage Terms

### **In-Network Coverage**

In-network providers have contracted rates they've pre-negotiated with insurance carriers. Typically, you will pay less with an in-network provider.

### **Out-Of-Network**

Out-of-network providers do not have pre-negotiated rates with your insurance carrier. You may pay more for eligible services with an out-of-network provider.

### **Primary Copay**

A predetermined rate you will pay every time you see your primary care physician.

### **Specialist Copay**

A predetermined rate you will pay every time you see a specialist.

### **Deductible**

The amount you will pay before your insurance carrier will pay for eligible expenses.

### **Embedded Deductible**

No single individual on a family plan will have to pay a deductible higher than the individual deductible amount. Once an individual on a family plan has met their individual deductible, coinsurance and/or copays will apply for continued services (based on the medical plan type).

### **Aggregate (Non-Embedded) Deductible**

All family members' out-of-pocket expenses count towards the family deductible until it is met. Once the family deductible is satisfied, coinsurance and/or copays will apply (based on the medical plan type) for continued services incurred by all family members.

### **Coinsurance**

After your deductible is met, this is the percentage of costs you will pay for covered services.

### **Out of Pocket Maximum**

The most you will pay for covered services in a plan year. Once this maximum is met through the deductible, copayments, and coinsurance, your health plan pays 100% of the costs of covered services. This does not include your payroll contribution.

### **Emergency Room**

The amount you pay to receive care for emergency services in a hospital facility.



## Glossary of Terms

### **Urgent Care**

The amount you pay to receive care for emergency services in an independent non-hospital facility.

### **Retail Rx Copay**

A predetermined rate you will pay for retail prescriptions.

### **Mail Order Copay**

A predetermined rate you will pay for mail order prescriptions.

### **Rx Deductible**

The amount you will pay before your insurance carrier will pay for eligible expenses on your prescription.

### **Guaranteed Issue**

The benefit amount that the carrier has agreed to approve coverage up to without requiring any health questions.

### **Evidence of Insurability**

Health questions that carrier will review when determining to approve or decline benefit amounts above the guaranteed issue.

### **Balance Billing**

The act of a provider billing a patient for the difference between the total cost of a service and the amount that the insurance carrier has agreed to cover for that service.



# Glossary of Terms

## Your Medical Insurance Card

### Group

This is unique to your company and is assigned by the insurance carrier. Healthcare providers and pharmacies use this to verify your coverage.

### ID (Member ID)

This number is unique to you. Healthcare providers and pharmacies use this to verify your coverage.

### RxBIN

This is an identifier that insurance carriers use for prescription billing.

### RxPCN

This is a secondary identifier that insurance carriers use for prescription billing.

## Plan Costs

### Your Contribution

The amount you contribute per pay period to be enrolled in the plan.

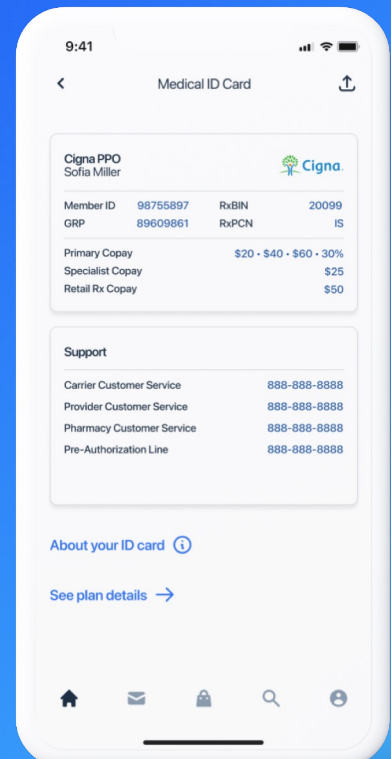
### Employer Contribution

The amount your employer contributes per pay period toward your enrollment in the plan.



## Section 8

# Required Healthcare Notices



## **Newborns' Act Disclosure**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## **Special Enrollment Notice**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself 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 Human Resources at [people@ramp.com](mailto:people@ramp.com).

## **WHCRA Enrollment Notice**

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

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

These benefits will be provided subject to the same copays, deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema?

If you would like more information on WHCRA benefits, please refer to your plan documents or contact your HR administrator.

## Michelle's Law Notice

Federal legislation known as "Michelle's Law" generally extends eligibility for group health benefit plan coverage to a dependent child who is enrolled in an institution of higher education at the beginning of a medically necessary leave of absence if the leave normally would cause the dependent child to lose eligibility for coverage under the plan due to loss of student status. The extension of eligibility protects eligibility of a sick or injured dependent child for up to one year.

The Plan currently permits an employee to continue a child's coverage past the child's 26th birthday until the child's 28th birthday if that child is enrolled at an accredited institution of learning on a full-time basis, with full-time defined by the accredited institution's registration and/or attendance policies. Michelle's Law requires the Plan to allow extended eligibility in some cases for a dependent child who would lose eligibility for Plan coverage due to loss of full-time student status.

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

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

For the Michelle's Law extension of eligibility to apply, a dependent child's treating physician must provide written certification of medical necessity (i.e., certification that the dependent child suffers from a serious illness or injury that necessitates the leave of absence or other enrollment change that would otherwise cause loss of eligibility).

If a dependent child qualifies for the Michelle's Law extension of eligibility, the Plan will treat the dependent child as eligible for coverage until the earlier of:

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

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

## Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, your Employer may not request or require any genetic information from you or your family members.

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

## HIPAA Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health plans protect the confidentiality of your health information. **RAMP** health plan maintains a privacy notice which explains HIPAA's privacy protections, your rights under HIPAA, and the circumstances under which our health plan may use or disclose your personal health information without your authorization.

Please contact [people@ramp.com](mailto:people@ramp.com) for a copy of this notice or for help with any other HIPAA privacy questions you may have.

## COBRA General Rights Notice

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the HR Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

## What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualified life events:

- your hours of employment are reduced, or
- your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

## **COBRA General Rights Notice (Continued)**

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than their gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Ramp Business Corporation, and that bankruptcy results in the loss of coverage of any retired employee under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

## **When will COBRA coverage become available?**

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer (applies to retiree coverage); or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your benefits administrator.

## **How is COBRA continuation coverage provided?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

## COBRA General Rights Notice (Continued)

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

- Disability extension of 18-month period of COBRA continuation coverage:
  - If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
- Second qualifying event extension of 18-month period of continuation coverage:
  - If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.
- Are there other coverage options besides COBRA Continuation Coverage?
  - Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children’s Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

**COBRA General Rights Notice (Continued)**

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

If you have questions:

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

Keep your Plan informed of address changes.

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Plan contact information:****Ramp Business Corporation****HR Department****people@ramp.com**

## 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](http://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](http://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](http://www.askebsa.dol.gov) or call **1-866-444-EBSA (3272)**.

**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025.**

**Contact your State for more information on eligibility.**

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### ALABAMA – Medicaid

Website: <http://myalhipp.com/>

Phone: 1-855-692-5447

### ALASKA – Medicaid

The AK Health Insurance Premium Payment Program Website: <http://myakhipp.com/>

Phone: 1-866-251-4861

Email: [CustomerService@MyAKHIPP.com](mailto:CustomerService@MyAKHIPP.com)

Medicaid Eligibility: <https://health.alaska.gov/dpa/Pages/default.aspx>

### ARKANSAS – Medicaid

Website: <http://myarhipp.com/>

Phone: 1-855-MyARHIPP (855-692-7447)

### CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website: <http://dhcs.ca.gov/hipp>

Phone: 916-445-8322

Fax: 916-440-5676

Email: [hipp@dhcs.ca.gov](mailto:hipp@dhcs.ca.gov)

**COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)**

Health First Colorado Website: <https://www.healthfirstcolorado.com/>

Health First Colorado Member Contact Center Phone: 1-800-221-3943/ State Relay 711

CHP+: <https://hcpf.colorado.gov/child-health-plan-plus>

CHP+ Customer Service Phone: 1-800-359-1991/ State Relay 711

Health Insurance Buy-In Program (HIBI): <https://www.mycohibi.com/>

HIBI Customer Service: 1-855-692-6442

**FLORIDA – Medicaid**

Website: <https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html>

Phone: 1-877-357-3268

**GEORGIA – Medicaid**

GA HIPP Website: <https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp>

Phone: 678-564-1162, Press 1

GA CHIPRA Website: <https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra>

Phone: 678-564-1162, Press 2

**INDIANA – Medicaid**

Healthy Insurance Premium Payment Program

All other Medicaid

Website: <https://www.in.gov/medicaid/>

Family and Social Services Administration

Website: <http://www.in.gov/fssa/dfr/>

Phone: 1-800-403-0864

Member Services Phone 1-800-457-4584

**IOWA – Medicaid and CHIP (Hawki)**

Medicaid Website:

[Iowa Medicaid | Health & Human Services](#)

Medicaid Phone: 1-800-338-8366

Hawki Website:

[Hawki - Healthy and Well Kids in Iowa | Health & Human Services](#)

Hawki Phone: 1-800-257-8563

HIPP Website: [Health Insurance Premium Payment \(HIPP\) | Health & Human Services \(iowa.gov\)](#)

HIPP Phone: 1-888-346-9562

**KANSAS – Medicaid**

Website: <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: [KIHIPPPROGRAM@ky.gov](mailto:KIHIPPPROGRAM@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.medicicaid.la.gov](http://www.medicicaid.la.gov) or [www.ldh.la.gov/lahipp](http://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](https://www.mymaineconnection.gov/benefits/s/?language=en_US)

Phone: 1-800-442-6003 TTY: Maine relay 711

**Private Health Insurance Premium**

Website: <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](mailto:masspremassistance@accenture.com)

**MINNESOTA – Medicaid**

Website: <https://mn.gov/dhs/health-care-coverage/>

Phone: 1-800-657-3739

**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: [HSHIPPPProgram@mt.gov](mailto:HSHIPPPProgram@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**

Website: <http://dhcfp.nv.gov>

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](mailto:DHHS.ThirdPartyLiabi@dhhs.nh.gov)

**NEW JERSEY – Medicaid and CHIP**

Medicaid Website:

[http://www.state.nj.us/humanservices/](http://www.state.nj.us/humanservices/dmahs/clients/medicaid/)

[dmahs/clients/medicaid/](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/](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**

Website: <https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html>  
Phone: 1-800-692-7462  
CHIP Website: [Children's Health Insurance Program \(CHIP\) \(pa.gov\)](#)  
CHIP Phone: 1-800-986-KIDS (5437)

**RHODE ISLAND – Medicaid and CHIP**

Website: <http://www.eohhs.ri.gov/>  
Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)

**SOUTH CAROLINA – Medicaid**

Website: <https://www.scdhhs.gov>  
Phone: 1-888-549-0820

**SOUTH DAKOTA – Medicaid**

Website: <http://dss.sd.gov>  
Phone: 1-888-828-0059

**TEXAS – Medicaid**

Website: [Health Insurance Premium Payment \(HIPP\) Program | Texas Health and Human Services](#)  
Phone: 1-800-440-0493

**UTAH – Medicaid and CHIP**

Utah's Premium Partnership for Health Insurance (UPP) Website: <https://medicaid.utah.gov/upp/>  
Email: [upp@utah.gov](mailto:upp@utah.gov)  
Phone: 1-888-222-2542  
Adult Expansion Website: <https://medicaid.utah.gov/expansion/>  
Utah Medicaid Buyout Program Website: <https://medicaid.utah.gov/buyout-program/>  
CHIP Website: <https://chip.utah.gov/>

**VERMONT – Medicaid**

Website: [Health Insurance Premium Payment \(HIPP\) Program | Department of Vermont Health Access](#)  
Phone: 1-800-250-8427

**VIRGINIA – Medicaid and CHIP**

Website: <https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select>  
<https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs>  
 Medicaid/CHIP Phone: 1-800-432-5924

**WASHINGTON – Medicaid**

Website: <https://www.hca.wa.gov/>  
 Phone: 1-800-562-3022

**WEST VIRGINIA – Medicaid and CHIP**

Website: <https://dhhr.wv.gov/bms/>  
<http://mywvhipp.com/>  
 Medicaid Phone: 304-558-1700  
 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

**WISCONSIN – Medicaid and CHIP**

Website: <https://www.dhs.wisconsin.gov/badgercareplus/p10095.htm>  
 Phone: 1-800-362-3002

**WYOMING – Medicaid**

Website: <https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/>  
 Phone: 1-800-251-1269  
 To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor  
 Human Services  
 Employee Benefits Security Administration  
[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)  
 1-866-444-EBSA (3272)  
 Ext. 61565

U.S. Department of Health and  
 Centers for Medicare & Medicaid Services  
[www.cms.hhs.gov](http://www.cms.hhs.gov)  
 1-877-267-2323, Menu Option 4,

**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](mailto:ebsa.opr@dol.gov) and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)



# Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved OMB No.  
1210-0149  
(expires 12-31-2026)

## PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

### What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

### Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%<sup>1</sup> of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.<sup>12</sup>

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

<sup>1</sup> Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

<sup>2</sup> An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

## When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

## What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

## How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact People Team.

**PART B: Information About Health Coverage Offered by Your Employer**

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<b>3. Employer name</b> Ramp Business Corporation		<b>4. Employer Identification Number (EIN)</b> 83-4047085	
<b>5. Employer address</b> 28 West 23rd Street Floor 2		<b>6. Employer phone number</b> (857) 202-3500	
<b>7. City</b> New York	<b>8. State</b> NY	<b>9. ZIP code</b> 10010	
<b><sup>10</sup>. Who can we contact about employee health coverage at this job?</b> People Team			
<b>11. Phone number (if different from above)</b>		<b>12. Email address</b> people@ramp.com	

Here is some basic information about health coverage offered by this employer:

As your employer, we offer a health plan to:

- All employees. Eligible employees are:** Full time employees working at least 30 hours per week

With respect to dependents:

- We do offer coverage. Eligible dependents are:** Spouses, domestic partners and/or legal dependent children
- **This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.**
- Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid- year, or if you have other income losses, you may still qualify for a premium discount.
- If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

## **Important Notice 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 offered through the Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The company has determined that the prescription drug coverage offered is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

### **When Can You Join A Medicare Drug Plan?**

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current coverage will not be affected.

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

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

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

Contact the person listed on the following page for further information.

**NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the company 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](http://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](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778).

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

**Date: January 2026**  
**Ramp Business Corporation Human Resources**  
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