2024-2025 TEAM MEMBER BENEFITS GUIDE

PROCESS TECHNOLOGY®

OPEN ENROLLMENT

OCTOBER 22– NOVEMBER 1, 2024

Dear Team Members:

Process Technology is pleased to once again offer a comprehensive benefits package that provides quality plans and programs for you and your family. We remain committed to providing you with the best plan options and tools to optimize your health, wellness and financial security.

Open Enrollment for your 2024-2025 benefit elections will take place from October 22 through November 1, 2024. The choices you make during this time will take effect on December 1, 2024, and remain in place until November 30, 2025. You must elect or waive benefits through UKG during Open Enrollment. **If you do not enroll by the deadline, you will not be eligible for coverage until the following annual open enrollment period unless you experience a qualifying event and** notify Talent Management within 30 days.

To ensure you are selecting the best benefit options for you and your family, please spend some time reviewing the plan information in this guide, including the costs and coverage levels. You will also find additional information on benefits and programs by visiting our Benefits Website at Process Technology (process-technologybenefits.com)

Please contact Talent Management if you have questions or need assistance with the enrollment process.

Sincerely,

Torino Fitzgerald
VP of Talent and Cultural Transformation

Important Contacts

oswald
A UNISON RISK ADVISORS Company

Be prepared: When contacting any of the companies below, it is important to have the insurance card or ID card number(s) of the subscriber for the coverage you are calling about as well as any appropriate paperwork, such as an explanation of benefits, a denial letter, receipts, etc.

Questions About	Contact	Phone	Website
Medical	Employee Benefit Management Services (EBMS)	1 (866) 326-7598	www.ebms.com mycigna.com
Prescription Drug	True Rx	1 (866) 921-4047	truerx.com/members
High-Cost Prescription Assistance	SHARx	1 (314) 451-3555	www.sharxplan.com
Health Savings Account	Optum Bank	1 (866) 234-8913 Option 4	www.optumbank.com
Telemedicine	Basic Care Plus (Recurro)	1 (888) 674-2490	www.247doctornow.com
Employee Assistance Program	Guardian	1 (800) 386-7055	lbhworklife.com
Diabetes and Health and Wellness Management	Gemcore	1 (888) 423-5220	www.gemcorehealth.com/enroll
Dental	Employee Benefit Management Services (EBMS)	1 (866) 326-7598	www.ebms.com
Vision	Employee Benefit Management Services (EBMS)	1 (866) 326-7598	www.ebms.com
Life / AD&D	Guardian	1 (888) 482-7342	www.guardianlife.com
Disability	Guardian	1 (888) 482-7342	www.guardianlife.com

If you need additional information, please visit Process Technology's Benefits Website:
Process Technology (process-technologybenefits.com)

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PROCESS TECHNOLOGY

Your Health Matters

ELIGIBILITY

As a benefits-eligible team member, Process Technology offers a health and welfare program that offers you and your family coverage that helps reduce your medical expense, improve your health and well-being, and protect you while you are an active team member working 30 hours or more.

DEPENDENT ELIGIBILITY

Your dependents may also be covered under the benefit plans described below.

Benefit	Legal Spouse	Dependent Child(ren)
Medical	√	Coverage terminates on the last day of the month in which the dependent reaches age 26
Dental	√	
Vision	√	

DEPENDENT VERIFICATION

You may be asked to provide Talent Management proof of dependent eligibility, which may include one or more of the following:

- Marriage Certificate
- Birth Certificate
- Affidavit of Qualifying Adult
- Adoption Certificate
- Placement Certificate
- Document of Guardianship
- Other as necessary

NEW HIRE COVERAGE

It is important you review the benefit information and enroll in benefits during your initial new hire eligibility period. If you do not enroll by that deadline, you will not be eligible for coverage until the following annual open enrollment period or if you experience a qualifying event. Following enrollment, your coverage is effective the first of the month following 30 days of service.

SPOUSAL COVERAGE

If your spouse is eligible for group health insurance through his or her employer, then he or she will not be eligible to obtain coverage under Process Technology's group health plan. You must complete the spousal carve out affidavit form to indicate your spouse's eligibility for participation in Process Technology's health plan. Please contact Talent Management to request the spousal carve out affidavit.

MEDICARE COVERAGE

If you (and/or) your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see page 28 for more details.

TERMINATION OF COVERAGE

If employment is terminated, all coverage will end on the last day of the month.

COBRA CONTINUATION OF COVERAGE

When you or any of your dependents no longer meet the eligibility requirements under this plan, you may be eligible for continued coverage as required by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

Making Changes During The Year

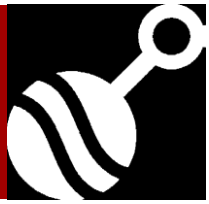
Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. You must notify Talent Management of such change(s) within the noted days from the event as shown in the below table. Failure to notify Talent Management within the timeframe noted (and provide any necessary dependent documentation) will require you to wait until the next open enrollment period to make your change. Qualifying events may require documentation of the event such as marriage certificate, birth certificate, divorce decree, etc. to finalize the event change. For questions, please see your Talent Management representative.

Qualifying Event	Timeframe to Notify Talent Management*
Marriage, divorce or legal separation	30 days
Birth, adoption or placement for adoption	30 days
Death of a dependent	30 days
Change in your spouse's employment status	30 days
Change in coverage status under your spouse's plan	30 days
A loss of eligibility for other health coverage	30 days
Change in dependent child's status, either newly satisfying the requirements for dependent child status or ceasing to satisfy them	30 days
Judgment, decree or court order allowing you to add or drop coverage for a dependent child	30 days
Change in eligibility for Medicare or Medicaid	60 days
Termination of eligibility for Medicaid or a state Children's Health Insurance Program (CHIP)	60 days
Becoming eligible for a premium assistance subsidy under Medicaid or a state CHIP	60 days

*Days from the qualifying event

Welcome Baby!

Don't forget to notify Talent Management within 30 days of birth of a newborn to add dependent(s) to the plan.



Making Changes During The Year

TURNING AGE 65 AND BECOMING MEDICARE ELIGIBLE

If you are an active team member and have reached the age of 65, you may be wondering about Medicare. If you are already receiving Social Security benefits, you should receive an advisory notice from Medicare about three (3) months before your 65th birthday for your initial enrollment period. Otherwise, you must actively enroll in Medicare yourself by contacting your local Social Security office as you will not receive a mailed notice of eligibility.

If you are turning age 65 during the plan year but will continue working in a benefits-eligible position, you have the option of enrolling in Medicare Part A (hospital) coverage, which is typically premium-free. You may also enroll in Part B (medical) coverage at your cost. If you do so, your Group Health medical plan remains your primary and Part B (Medical Insurance), which does have a fee involved, would coordinate as secondary coverage to your Group Health medical plan.

Medicare will allow you to delay your enrollment in Medicare Part B until you officially retire, without a late enrollment penalty (enrollment in Medicare Part A is optional). Team members more typically enroll in Part A and defer Part B until retirement. For additional information on Medicare eligibility and enrollment periods, please visit www.Medicare.gov.

IMPORTANT: BENEFICIARY DESIGNATION

In addition to electing or making benefit changes during open enrollment, it is important to designate a beneficiary for your life insurance and Health Savings Account (HSA). Your beneficiary is the person(s) who will receive your life insurance benefits and any remaining HSA balance when you die. If you have a beneficiary in place, or if your family situation has changed, now is the time to ensure all information on record is correct. If you do not name a beneficiary, your benefits will automatically go to your estate. For additional information contact Talent Management.

Cost of Coverage Summary- Medical

2024-2025 PAYROLL DEDUCTIONS (26 WEEKS)

Per-Pay Rate	RBP HSA	RBP PPO	Cigna HSA	Cigna PPO
Team Member Only	$95.00	$95.00	$142.50	$142.50
Team Member + Spouse	$165.38	$165.38	$275.63	$275.63
Team Member + Child	$110.25	$110.25	$183.75	$183.75
Family	$165.38	$165.38	$275.63	$275.63

Wellness Discount Opportunities

	Non-Nicotine Credit	Preventive Care Credit
Single, Single+ Child	$30 discount	Additional $30 discount
Single + Spouse	$30 discount	Additional $60 discount
Family	$30 discount	Additional $60 discount

We are committed to helping you achieve your best health. Rewards for being nicotine free and participating in a health screening available to all Team Members on the medical plan. If you think you might be unable to meet a standard for the rewards listed above, you might qualify for an opportunity to earn the same reward by different means. Talent Management will work with you (and, if you wish, with your doctor) to offer a program for you that will provide you the same reward.

Cost of Coverage Summary- Dental & Vision

2024-2025 PAYROLL DEDUCTIONS (26 WEEKS)

Per-Pay Rate	Dental and Vision
Team Member Only	$10.00
Team Member + Spouse	$15.00
Team Member + Child	$15.00
Family	$15.00

Cost of Coverage Summary (Continued)

Health Savings Account Contributions

2024 & 2025 HSA CONTRIBUTION LIMITS	Team Member Only		Family	
	2024	2025	2024	2025
Annual Maximum Contribution	$4,150/year	$4,300/year	$8,300/year	$8,550/year
Team Member Maximum Contribution **after** Employer contribution	$3,400/year	$3,550/year	$6,800/year	$7,050/year
Employer Contribution	$750/year	$750/year	$1,500/year	$1,500/year

Team Members age 55+ in 2024 or 2025 may contribute an additional $1,000

UNDERSTANDING YOUR PRE-TAX BENEFIT PAYROLL DEDUCTIONS

The Section 125 Cafeteria Plan allows you to pay for many of the benefits we offer with “before-tax” dollars (e.g., medical, dental and vision coverage). By paying premiums with “before-tax” dollars, you may reduce the amount of income and Social Security taxes that you otherwise would be required to pay. The elections made during the Cafeteria Plan enrollment period are effective for the entire 12-month plan year. Unless you experience a life-changing qualifying event, you cannot make changes to your benefits until the next open enrollment period. Refer to the preceding page of this Benefits Guide for information on what constitutes a qualifying event, and the associated timeframe you must notify Talent Management if you intend to make a change.

Medical Plan-Reference Based Pricing

The following is a summary of your medical benefits. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), Certificate of Coverage or SBC. You may access a list of participating providers through mibenefits.ebms.com

1 (866) 326-7598

Services	HDHP Plan		PPO Plan	
Deductible	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Per Plan Participant	$2,500	$3,000	$300	$600
Per Family Unit	$5,000	$6,000	$900	$1,800
Out-of-Pocket Maximum				
Per Plan Participant	$2,500	$4,500	$2,000	$4,000
Per Family Unit	$5,000	$9,000	$6,000	$12,000
Coinsurance				
Plan Pays	100%	60%	80%	60%
You Pay	0%	40%	20%	40%
Covered Services				
Office Visit				
Primary Care	100% After Deductible	60% After Deductible	80%, No Deductible Applies	60%, After Deductible
Specialist	100% After Deductible	60% After Deductible	80%, No Deductible Applies	60% After Deductible
Preventive Care	No Charge	No Charge	No Charge	No Charge
Urgent Care				
Facility	100% After Deductible		80% After Deductible	
Physician	100% After Deductible	60% After Deductible	80% After Deductible	60% After Deductible
Emergency Room				
ER Copay	100% after deductible, then $500 copay per visit (waived if admitted)		$500 copay per visit, then 80% after deductible (copay waived if admitted)	
Diagnostic Lab				
Facility	100% After deductible		80% After deductible	
Physician	100% After deductible		80% After deductible	
Inpatient Stay				
Facility	100% After deductible		80% After deductible	
Physician	100% After deductible	60% After deductible	80% After deductible	60% After deductible

NEW Medical Plan - Cigna

The following is a summary of your medical benefits. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), Certificate of Coverage or SBC. You may access a list of participating providers through mibenefits.ebms.com

1 (866) 326-7598

Services	HDHP Plan		PPO Plan	
Deductible	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
Per Plan Participant	$2,500	$3,000	$500	$1,000
Per Family Unit	$5,000	$6,000	$1,500	$3,000
Out-of-Pocket Maximum				
Per Plan Participant	$5,000	$10,000	$5,000	$10,000
Per Family Unit	$10,000	$20,000	$10,000	$20,000
Coinsurance				
Plan Pays	80%	60%	80%	60%
You Pay	20%	40%	20%	40%
Covered Services				
Office Visit				
Primary Care	80% After Deductible	60% After Deductible	80% No Deductible	60% After Deductible
Specialist	80% After Deductible	60% After Deductible	80% No Deductible	60% After Deductible
Preventive Care	No Charge	No Charge	No Charge	No Charge
Urgent Care				
Facility	80% After Deductible	60% After Deductible	80% After Deductible	60% After Deductible
Physician	80% After Deductible	60% After Deductible	80% After Deductible	60% After Deductible
Emergency Room				
ER Copay	80% after deductible, then $500 copay per visit (copay waived if admitted)		$500 copay per visit, then 80% after deductible (copay waived if admitted)	
Diagnostic Lab & X-Ray				
Facility	80% After deductible	60% After Deductible	80% After deductible	60% After Deductible
Physician	80% After Deductible	60% After Deductible	80% After Deductible	60% After Deductible
Inpatient Stay				
Facility	80% After deductible	60% After Deductible	80% After deductible	60% After Deductible
Physician	80% After Deductible	60% After Deductible	80% After Deductible	60% After Deductible

Emergency Room / Urgent Care

KNOW WHERE TO GO

If you're faced with a sudden illness or injury, making an informed choice on where to seek medical care is crucial to your personal and financial well-being. Making the wrong choice can result in delayed medical attention and may cost hundreds, if not thousands, of dollars. More than 10 percent of all emergency room visits could have been better addressed in either an urgent care facility or a doctor's office.

If you're suddenly faced with symptoms of an illness or injury, how can you determine which facility is most appropriate for your condition?

EMERGENCY ROOM	**URGENT CARE**
The **emergency room (ER)** is equipped to handle life- threatening injuries and illnesses and other serious medical conditions. Patients are seen according to the seriousness of their conditions in relation to the other patients.	**Urgent care centers** are not equipped to handle life-threatening injuries, illnesses or medical conditions. These centers are designed to address conditions where delaying treatment could cause serious problems or discomfort.
You should go to the nearest ER if you experience any of the following: • Compound fractures • Deep knife or gunshot wounds • Moderate to severe burns • Poisoning or suspected poisoning • Seizures or loss of consciousness • Serious head, neck or back issues • Severe abdominal pain • Severe chest pain or difficulty breathing • Signs of a heart attack or stroke • Suicidal or homicidal feelings • Uncontrollable bleeding	Some examples of conditions that require a visit to an urgent care center include: • Controlled bleeding or cuts that require stitches • Diagnostic services (x-rays, lab tests) • Ear infections • High fever or the flu • Minor broken bones (e.g., toes, fingers) • Severe sore throat or cough • Sprains or strains • Skin rashes and infections • Urinary tract infections • Vomiting, diarrhea or dehydration

REMEMBER: Unless it is a true emergency – a serious or life-threatening condition that requires immediate treatment that is only available in a hospital – consider your options for appropriate, quality care that is efficient and economical.

DON'T PAY MORE IF YOU DON'T HAVE TO:

Convenience Care Clinics are walk-in clinics typically located in a supermarket, pharmacy or retail store, where available. Services may be provided at a lower out-of-pocket cost compared to urgent or emergency care as they are subject to primary care office visit copays and/or coinsurance. Convenience care clinics are suitable for non-life-threatening immediate care.

Examples include: common infections (ear, bladder, pink eye, strep throat), minor skin conditions, allergies, and more.

Prescription Drugs - Reference Based Pricing

https://truerx.com/members/ 1-866-921-4047

PRESCRIPTION-TrueRx

The following is a summary of your medical benefits. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), Certificate of Coverage or SBC. You may access a list of participating providers through the carrier's website.

PRESCRIPTION DRUGS:

30-day supply at retail pharmacy

90-day mail order available

Prescription Drug - Retail	HDHP	PPO
Generic	0% coinsurance per prescription after medical deductible	$10 Copay
Preferred Brand		$30 Copay
Non-Preferred Brand		$75 Copay
Specialty	Must use SHARx	Must use SHARx
Prescription Drug - Mail Order	**HDHP**	**PPO**
Generic	0% coinsurance per prescription after medical deductible	$20 Copay
Preferred Brand		$60 Copay
Non-Preferred Brand		$150 Copay
Specialty	Must use SHARx	Must use SHARx

See Summary Plan Description for additional details. You may also contact the plan administrator regarding benefits.

Prescription Drugs-Cigna

https://truerx.com/members/ 1-866-921-4047

PRESCRIPTION-Cigna

The following is a summary of your medical benefits. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), Certificate of Coverage or SBC. You may access a list of participating providers through the carrier's website.

PRESCRIPTION DRUGS:

30-day supply at retail pharmacy

90-day mail order available

Prescription Drug - Retail	HDHP	PPO
Generic	0% coinsurance per prescription after medical deductible	$10 Copay
Preferred Brand		$30 Copay
Non-Preferred Brand		$75 Copay
Specialty	Applicable drug tier copayment applies*	
Prescription Drug - Mail Order	**HDHP**	**PPO**
Generic	0% coinsurance per prescription after medical deductible	$20 Copay
Preferred Brand		$60 Copay
Non-Preferred Brand		$150 Copay
Specialty	Not covered	

*SHARx is not available for J codes (provider administered infusions/injections).

See Summary Plan Description for additional details. You may also contact the plan administrator regarding benefits.

Health Savings Account

WHAT IS A HEALTH SAVINGS ACCOUNT?

A Health Savings Account, commonly known as an "HSA," is an individual account you can open, add money to, and spend on eligible healthcare expenses. If you elected the high deductible health plan, you are eligible for an HSA.

SETTING UP YOUR HSA

Once you set up your HSA, any payroll deductions you have elected may begin. It is important to get your HSA set up as quickly as possible because you cannot turn in expenses incurred before the account was set up.

ADDING MONEY

The government sets the annual dollar maximum that can be contributed to an HSA depending on the level of coverage you have under your health insurance. Coverage of two or more people is considered family coverage. People who are age 55 or older can make additional catch-up contributions.

USING HSA MONEY

You decide when to spend money from your HSA. If you pay out of pocket for an eligible medical expense, you can choose to not reimburse yourself and let the money in your HSA build up or you can reimburse yourself for the expense from your HSA.

If you use your HSA money for expenses that are not eligible, you will pay a 20% penalty plus income tax on the amount. Once you turn age 65, you may use your HSA money for any expense, medical or not, but you will pay income taxes on those non-medical expenses. To view the full list of eligible expenses, visit www.irs.gov/publications and refer to Publication 969.

HSA Maximum 2025 Contribution Limits (Team Member + Employer)

	2025
Team Member Only	$4,300
Team Member + Dependent(s)	$8,550
55+ Catch-Up	$1,000

Note: It is your responsibility to familiarize yourself with IRS regulations on HSAs and maintain records of all transactions pertaining to your HSA for audit purposes.

ELIGIBLE EXPENSES

The money in your HSA must be used for eligible medical, dental, vision, and prescription drug expenses. In general, eligible expenses are those that qualify toward the deductibles, copays, and coinsurance with your health plan. If you use money for a dental, vision or medical expense that is not covered by the medical plan, it is important you understand your medical plan deductible still needs to be met if an expense is incurred.

Portability	Flexibility	Tax Savings
• You own 100% of the deposited funds, meaning if you change employers or retire, you do not lose the money in the accounts regardless of whether you contributed the money or if it was an employer contribution	• You can choose whether to spend the money on current medical expenses or you can save your money for future use • Any unused funds will automatically roll over to the following year as there is no "use it or lose it" provision	• Contributions are tax free (pre-tax through payroll deductions or tax deductible) • Earnings are tax free • Funds withdrawn for eligible medical expenses are tax free

Dental Coverage

The following is a summary of your dental benefits. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), Certificate of Coverage or benefit summary. There is no network for dental coverage, which means you have open access to see any provider in your area. The provider just needs to reach out to EBMS for benefit and eligibility verification.

BENEFITS AT-A-GLANCE

1 (866) 326-7598

	Open Access
Deductibles*	
Per plan participant Per family unit *applies to class B & C	$50 $100
Maximum Benefit	
Class A, B, & C Services Class D Services	$1,000 per calendar year $1,000 per lifetime
Class A - Preventive	
Routine exams, bitewing x-rays, sealants	100%, no deductible applies
Class B - Basic	
Panoramic x-rays, endodontic procedures, extractions	80% after deductible
Class C - Major	
Inlays, onlays, crows, prosthetics	50% after deductible
Class D - Orthodontia	
Orthodontic services*	50%, no deductible applies

***Orthodontia services are covered for Plan Participants up to age 19.**

Vision Coverage

The following is a summary of your vision benefits. The vision care network consists of private practicing optometrists, ophthalmologists, opticians and optical retailers. For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), Certificate of Coverage or benefit summary. There is no network for vision coverage, which means you have open access to see any provider in your area. The provider just needs to reach out to EBMS for benefit and eligibility verification.

BENEFITS AT-A-GLANCE

1 (866) 326-7598

	Open Access
Eye Exam	**Maximums**
1 exam per calendar year	$100 per exam
Frames	
1 frame per calendar year	$100 per frame
Lenses	
1 pair per calendar year*	Single Vision - $100 per pair Bifocals - $150 per pair Trifocals - $200 per pair Lenticular Single Vision - $75 per pair Lenticular Bifocals - $125 per pair Lenticular Trifocals - $150 per pair Progressive - $150 per pair
Contact Lenses (medically necessary)	
1 pair per calendar year*	Medically Necessary - $175 per pair
Contact Lenses (elective)	
1 pair per calendar year*	$100 per pair

***Benefits available for lenses may be used for contact lenses in lieu of lenses.**

Basic Life and Accidental Death & Dismemberment Insurance

Basic Life insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed at the company. Accidental Death and Dismemberment (AD&D) insurance is equal to your life insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits in certain injury instances.

REMINDER: Please be sure to review your beneficiary information to ensure it is up to date.

BENEFITS AT-A-GLANCE

www.guardianlife.com

1-888-482-7342

	BASIC LIFE AND AD&D COVERAGE
Basic Life Insurance	Two times Earnings Minimum $50,000 Maximum $300,000
Accidental Death and Dismemberment	Two times Earnings Minimum $50,000 Maximum $300,000
Benefit Reduction Schedule	50% at age 70

This benefit is available the first of the month following 30 days of employment.

ACTIVELY AT WORK REQUIREMENT

Team Member Eligibility Requirements for Life Insurance:
You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you will begin once you have returned to work.

For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), Certificate of Coverage or benefit summary.

Voluntary Accidental Death & Dismemberment Insurance

Voluntary Life insurance provides a monetary benefit to your beneficiary in the event of your death while you are employed at the company. Accidental Death and Dismemberment (AD&D) insurance is equal to your life insurance benefit amount and is payable to your beneficiary in the event of your death as a result of an accident and may also pay benefits in certain injury instances.

REMINDER: Please be sure to review your beneficiary information to ensure it is up to date.

BENEFITS AT-A-GLANCE

www.guardianlife.com 1-888-482-7342

	VOLUNTARY LIFE AND AD&D COVERAGE
Voluntary Team Member Life Insurance	$10,000 to $500,000 in $10,000 increments
Voluntary Spouse Life Insurance	$5,000 to $250,000 in $5,000 increments
Voluntary Dependent Child Life Insurance	$5,000 or $10,000
Accidental Death and Dismemberment	100% of life benefit to $500,000
Benefit Reduction Schedule	50% at age 70

This benefit is available the first of the month following 30 days of employment.

ACTIVELY AT WORK REQUIREMENT

Team Member Eligibility Requirements for Life Insurance:
You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you will begin once you have returned to work.

Dependent Eligibility Requirement for Life Insurance: A dependent confined to a hospital on the date on which insurance would normally begin will become insured upon discharge from the hospital.

For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), Certificate of Coverage or benefit summary.

Voluntary Accidental Death & Dismemberment Insurance

EVIDENCE OF INSURABILITY (EOI) REQUIREMENTS

Team Members that have previously waived Voluntary Team Member, Spouse or Dependent Child Life insurance will require EOI. The re-enrollment feature allows Team Members currently enrolled in Voluntary Team Member Life to elect to increase their coverage up to $50,000, not to exceed the guaranteed issue amount of $150,000 - without EOI.

You are not eligible to elect any increase in Voluntary Spouse and/or Dependent Child Life unless go through EOI process, and it's approved by Guardian. Team Members will receive an email or letter from Guardian with instructions and a unique link to submit your EOI form online.

Once Guardian receives the EOI form, they will contact you with any questions, before notifying your employer if the coverage amount is approved. Coverage and payroll deduction are effective the first of the month following Guardian's approval.

Voluntary Team Member & Spouse Life and AD&D Rates

TEAM MEMBER & SPOUSE VOLUNTARY LIFE RATES PER $1,000										
AGE	<30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
RATES	$0.090	$0.087	$0.124	$0.202	$0.340	$0.553	$0.943	$1.258	$1.955	$4.023

VOLUNTARY DEPENDENT CHILD LIFE RATES PER $1,000
$0.184

VOLUNTARY AD&D RATES PER $1,000	
Team Member	$0.040
Spouse	$0.040
Child	$0.040

Short-Term & Long-Term Disability

Short Term Disability Insurance provides income protection in the event you become disabled and are unable to work due to sickness or non-occupational injury, including pregnancy, for a short period of time.

www.guardianlife.com 1-888-482-7342

Short Term Disability

Benefit Amount	66 and 2/3 percent of weekly earnings
Benefits Begin After	0 days for accident 7 days for illness
Maximum Weekly Amount	$1,000
Maximum Benefit Period	26 weeks

This benefit is available the first of the month following 30 days of employment.

LONG TERM DISABILITY

Benefit Amount	60% of monthly earnings
Benefit Maximum	$7,500 monthly
Definition of Disability	After 24 months you are considered disabled if you are unable to perform material duties of any gainful occupation for which you are reasonably fitted by education, training or experience.
Benefits Begin After	180 days
Maximum Benefit Period	To age 67 or if disabled at or after age 65 benefits payable according to an age - based schedule.
Pre-Existing Waiting Period	The policy will not cover any disabilities during the first 12 months after the covered person's effective date of insurance that is caused or contributed by any sickness or injury for which the covered person sought treatment during the three months prior to the effective date of coverage.

ACTIVELY AT WORK PROVISION

Team Member Eligibility Requirements for Disability Insurance

You must be actively at work on the day coverage is scheduled to begin. If you are not actively at work on that day, coverage for you will begin once you have returned to work.

For a more detailed explanation of benefits, please refer to your Summary Plan Description (SPD), Certificate of Coverage or benefit summary.

miBenefits Portal

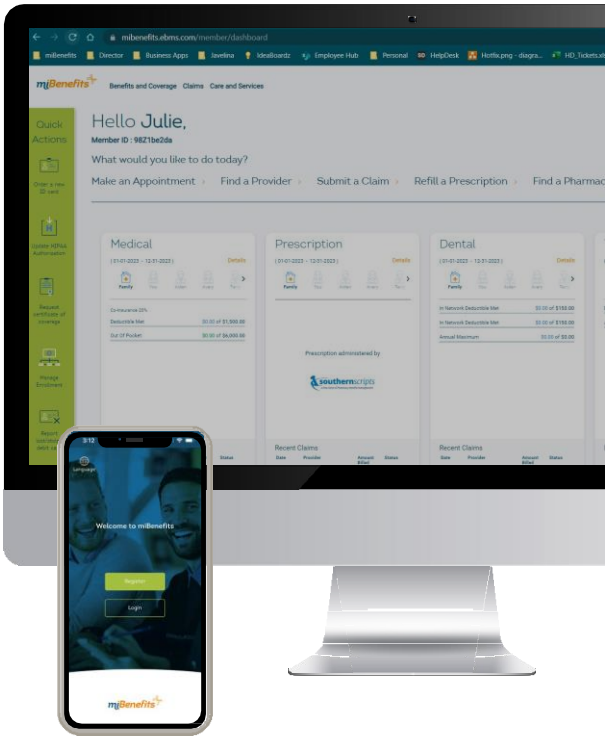
24/7 Access to Your Health Benefits

Your dynamic miBenefits portal instantly connects you to important plan information and powerful resources.

A user-friendly dashboard makes it easy to:

- Take full advantage of your benefits
- Manage your healthcare better
- Track your plan spending

Sign up now!
Quick registration. Simple benefits management. mibenefits.ebms.com



What Would You Like to Do Today?

The miBenefits portal is full of features for every stage of your healthcare journey. You can:

- Find a provider that's right for you
- Order a new Benefits ID card
- Get real-time claims status
- See where your deductible and out-of-pocket expenses stand
- Review benefits for each family member
- Access electronic Explanation of Benefits copies

Manage your benefits anywhere, anytime.
Download the free "miBenefits" portal app.

Download on the App Store | GET IT ON Google Play

Questions about the miBenefits portal? We're here to help.
Call us at the number on your Benefits ID card.

ebms

Find a Provider That's Right for You

Through the miBenefits portal

Our online provider search tool helps you make an informed choice by letting you quickly compare:

- Provider quality
- How well a provider works with your plan
- Cost estimates for care

Where Do I Find the Provider Search?

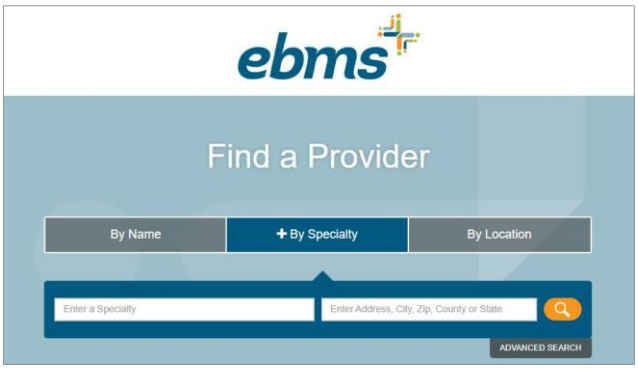
Go to the miBenefits portal, which connects you to important plan information and resources.

- Register for the portal at **mibenefits.ebms.com**.
- Download the free **"miBenefits" portal app**.

Download on the App Store | GET IT ON Google Play

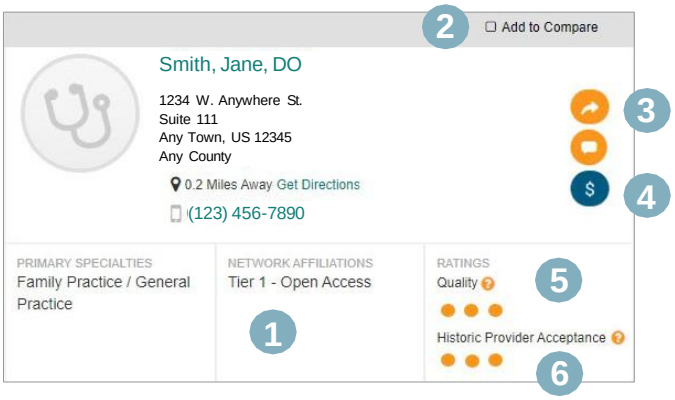
Start Your Provider Search

In miBenefits, click **"Find a Provider"** in the **Manage My Health** section. To get started, simply enter the information you want to search by.



The search tool lets you:

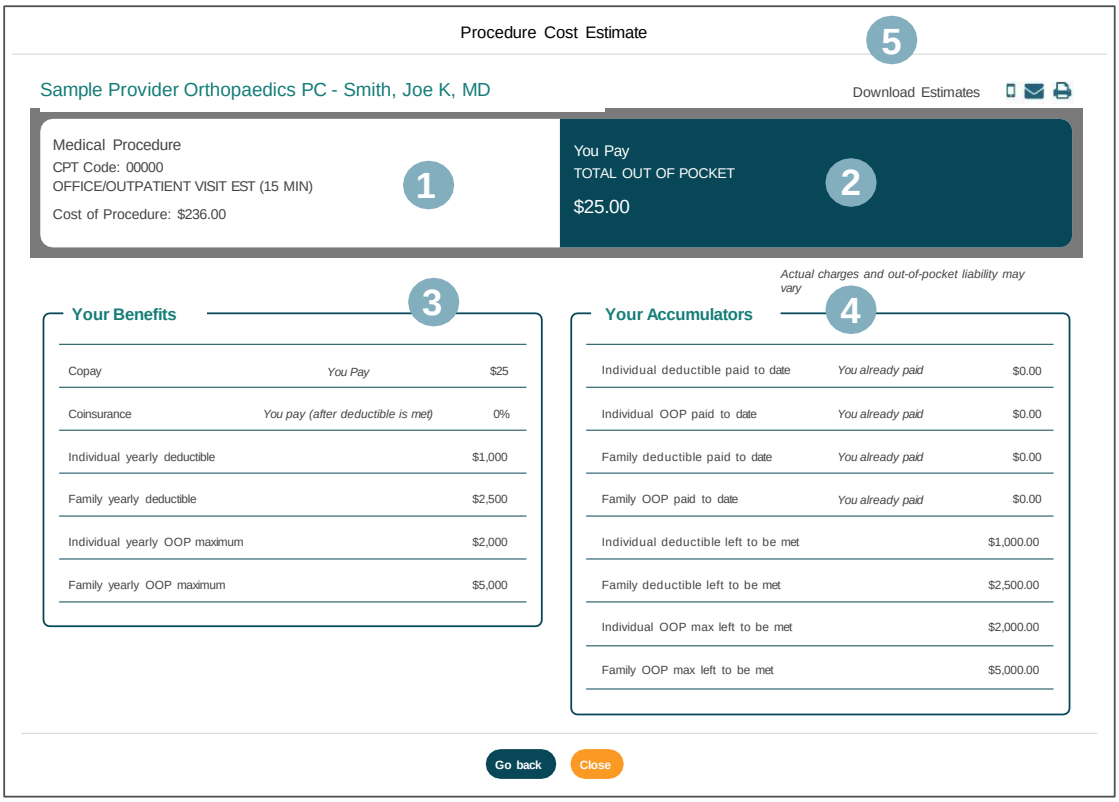
1. View the provider's network.
2. Compare to other providers.
3. Send results to your mobile phone.
4. Get a procedure cost estimate.
5. See a provider's quality rankings.
6. Learn how well the provider works with your plan.



ebms

Understand Your Costs

The cost estimator option gives you instant price estimates for a provider's care. Follow the prompts to find a specific procedure and see your total out-of-pocket cost. You can also compare prices from multiple providers.



Each estimate provides:

1. Procedure information, including the cost before the member's benefits are applied.
2. Your out-of-pocket procedure cost, including your co-pay (if applicable).
3. Information about your benefits plan.
4. Total accumulated toward your annual deductibles and out-of-pocket maximum.
5. Ability to text, email or print a cost estimate.

Want help finding a provider?

Just call the number on your Benefits ID card. Our Member Experience team offers complete guidance so you can get the care you need.

Questions? We're here to help.
Call EBMS at the number on your Benefits ID card.
Mon – Thurs: 6 a.m. – 8 p.m. MT | Fri: 6 a.m. – 6 p.m. MT

Care Navigation: Get help finding the right care for you

Finding the right healthcare provider is an important step when it comes to taking care of your health. Your health plan offers Care Navigation Services, which can make it easy to find a provider that fits your needs and works well with your benefits.

With the latest information on more than 200,000 doctors and facilities nationwide, our team of experts can help you:

- Find physicians or facilities near you.
- Compare providers based on quality scores and costs.
- Determine if they have historically accepted your plan's reimbursement.
- Help you select the provider that works best for you.

Getting this information can help you feel more confident in your choice of provider before you schedule a visit.

Personalized Customer Service

If you have any questions at any stage of your care, our team is here for you. Whether you have specific questions about your health plan, or need help finding a provider, give us a call.

Call the Number on Your Benefits ID Card today to Get Started!

Our team can walk you through the process of selecting a healthcare partner from the beginning, so you have fewer issues later. Your health plan may also include online access to this provider research at your convenience. Just ask about this option when you call.

ebms | elap services

The Balance Billing Cycle

Don’t break the bank. Let us break the cycle.

You work hard for your money. The last thing you want to do is pay a medical bill without knowing if you are overpaying. As your health plan’s partner, ELAP Services (ELAP) reviews medical claims for potential errors and to make sure charges don’t exceed your plan’s limits.

What you Need to Know: Most providers will accept a fair payment from your plan. However, some providers may send you a bill for the difference between what your plan paid and the amount they charged. If that happens, ELAP is here to help!

YOUR PART: Identify Balance Bills

Compare the EOB and the Provider Bill

After receiving medical care, keep an eye out for the Explanation of Benefits (EOB) from your health plan and a Provider Bill sent by the doctor or facility.

Compare the “amount you owe” on the EOB and bill. If they don’t match, this is a balance bill. ELAP will help!

Send Bills to ELAP

Send any balance bills you receive to ELAP right away so we can get to work! You can rely on us to address any billing issues with the provider.

OUR PART: Advocate on Your Behalf

Pay Confidently with ELAP’s Support

Once we have your written permission, ELAP will work to resolve the bill with the provider on your behalf. We will:

- Assign a dedicated Member Services Advocate to support you and provide regular updates
- Arrange for comprehensive legal support at no extra cost, if necessary
- Provide access to live and online support

Send your balance bill to ELAP. It’s easy!

Email a clear snapshot from your phone or computer to:

bb@elapservices.com

Fax a copy:

1-888-560-2447

Mail a copy:

1550 Liberty Ridge Drive
Suite 330, Wayne, PA 19087

Support is a phone call away

1-800-977-7381 (Hours: 8 am – 8 pm EST)

EMAIL: bb@elapservices.com

TrueRx

PRESCRIPTION DRUG BENEFIT

Process Technology has elected to provide several common preventive care prescription drugs through True Rx.

Depending on your plan, some of the preventive care medications may require prior authorization in order to be covered at no cost to you. A prior authorization process is a simple process. Please notify your doctor or call **customer service at 1-866-921-4047**, if you are asked for prior authorization.

Please note, if you have a prescribed brand name prescription drug that had a direct generic, only the generic is covered at no cost to you.

If you have questions about a specific drug is covered, you may:

- Check the formulary at https://truerx.com/formulary
- Download the True Rx mobile App and use the search box for the drug
- Call True Rx Customer Service at 1-866-921-4047 between 8:00am and 6:00pm EDT, Monday through Friday.

True Rx offers a mobile app for both iPhone and Android devices. This app provides you access to your health information *wherever* you need it, *whenever* you need it.

Through the member mobile app, you can:

- View your prescription card
- View your most current list of prescriptions & claims
- Find drug information
- Locate in-network pharmacies with maps, directions, and pharmacy information
- Price a drug at multiple pharmacies
- Set a preferred pharmacy to be used each time a drug is priced

SHARx Prescription Assistance

What is SHARx?

SHARx is an advocacy solution provided by your employer. This program was created to extend advocacy program benefits to Team Members like you. Our role is to help facilitate the advocacy process for each eligible member of your employer's health plan and provide access for all high-cost medications.

As it can take a few weeks to get set up, now is the time to begin the process to access your high-cost medications.

Who is Eligible?

Your employer is making this program available to members enrolled in the health plan. If you are currently on a high-cost prescription medication, you will want to follow the steps below for potential cost savings to you! If you are eligible to participate in the SHARx program to lower drug costs for you and your family, follow the instructions in the welcome email or call 314-451-3555.

Instructions to Create Your Advocacy Request

If you have been identified as having a high-cost medication, you will receive a welcome email from SHARx.

After receiving the email, please follow the instructions in the email:

1. **Click on the custom link in the email to create an account on the SHARx platform.**
2. **Validate your identity and set up a user account for the website.**
3. **After logging in, you can verify the prescription information we have on file for you (and your dependents).**
4. **Sign the HIPAA form and we'll get to work finding the best option for your medication(s).**

If you do not receive a welcome email or are prescribed a high-cost medication in the future, please email sharx@sharxplan.com or call 314-451-3555.

SHARx Continued

What are the costs?

There are no costs to participate in the SHARx program. Your employer has paid 100% of the cost of this service for you and your family as long as you are enrolled in your employer's health plan. Prescriptions obtained through this service could be FREE for you and your family. Sometimes a co-pay or out of pocket amount will be required, but this out of pocket may be substantially less than what you are paying now.

What happens if I don't enroll in the SHARx program?

Your high-cost medications will no longer be covered by your employer pharmacy benefit plan.

If you are in the advocacy process with SHARx, you may be eligible for a short supply of your urgent medications at your local pharmacy while the advocacy is in process.

Certain manufacturers will require additional information to verify your income.

Please respond right away to these requests for additional information to ensure there is no delay with your advocacy.

Our goal is for everyone to receive the medications they need as quickly as possible at the lowest price, and this is only accomplished with your help.

What is considered a High-Cost Prescription?

Any medication that has a cost of at least $350 per month is considered high-cost.

SHARx Continued

What can I expect?

It is important to note that this is not an overnight solution and usually takes from two to four weeks on average to implement your cost savings, depending on outside circumstances of doctor cooperation, ease of communication and understanding. You may also be asked to verify your income, so please respond right away. Be patient with this process and realize that SHARx advocates want to help you.

How will I receive my prescriptions that are not high-cost?

You will continue to use your same pharmacy for acute and low-cost maintenance medications. You are welcome to see if the SHARx program can save you money on low-cost maintenance medications by visiting www.sharxplan.com/generics. Often you can receive a year's supply of maintenance medications for less than you would pay over the course of a year using your insurance copays. Use coupon code SHARx5 for $5 off your first order.

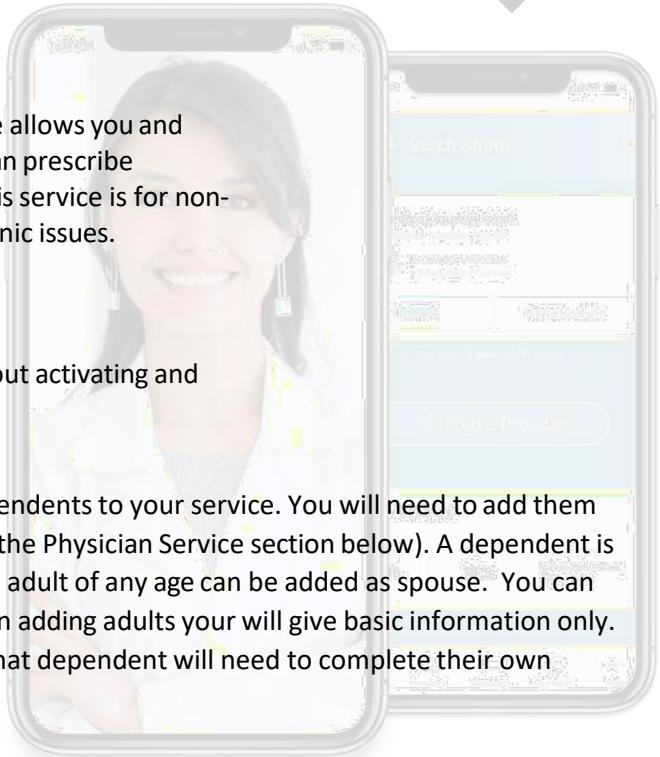
A glimpse into how SHARx can help you too!

"SHARx has really saved my life and I cannot thank them enough for all of their help! I have multiple medical problems and without them it would simply boil down to deciding what to go without!"

Watch this video to learn more about SHARx!

Telehealth Services

BasiCare Plus®



Welcome to your BasiCare Plus® telemedicine. This service allows you and your family to speak with a doctor for free, 24/7. Doctors can prescribe prescriptions and will do so to your preferred pharmacy. This service is for non-emergency use and is designed for common illness, not chronic issues.

Doctors are board certified and licensed in your state.

IMPORTANT: This letter contains important information about activating and using your services. Please keep this letter for reference.

A NOTE ABOUT DEPENDENTS: You may add up to eight dependents to your service. You will need to add them to your physician service when activating your account (see the Physician Service section below). A dependent is someone in your direct care that is under the age of 26. One adult of any age can be added as spouse. You can add minor dependents (under age 18) on your own but when adding adults your will give basic information only. Once you have provided the adult dependent information, that dependent will need to complete their own activation.

Physician service: We provide your free doctor visits through the Recuro® network. To use your telemedicine, you must first activate service through one of the options below. During activation, you will be asked to provide medical information and information about your dependents during this process. Your benefit includes up to eight dependents (see *Dependent Instructions* above). If you have already activated your service, you will not need to repeat this step.

There are three options for activating and using your physician benefit:

1. Visit ***www.247doctornow.com***
2. Call 888-241-4302
3. Download the Recuro Care® app for your smartphone

Telemedicine is NOT appropriate for chronic or emergency issues such as chest pain, stroke symptoms, high blood pressure, diabetes, and heart disease. ALL chronic or emergency issues should be handled by your physician or the local Emergency Room. Use your telemedicine service for common occasional illness. Our physicians have provided consultations on the following and more:

Common Doctor Consultations: Aches, allergy, asthma, bronchial, cold, earache, flu, cough, sinus infections, sore throat, croup, diarrhea, itching/red/sore eyes, fever, headache, infection, intestinal cramping, pain, nausea, vomiting, strep throat, tonsillitis, urinary tract infection, viral infection, bee sting, insect bites, muscle spasm, rash, yeast infection, swelling, cold sores, eczema, poison ivy/oak/sumac, hay fever, and more…

Employee Assistance Program

Employee Assistance Program Overview

- Our comprehensive Employee Assistance Program (EAP), available through Uprise Health, provides you and your family members with confidential, personal and online/web-based support on a wide variety of important and relevant topics — such as stress management, dependent/elder care, nutrition, fitness, and legal and financial issues.

- **Employee assistance program consultative services**
- **Online modules and coaching** — learn, develop, and practice new skills to improve mental fitness; includes a well-being check, online modules selected specifically for you, and up to 3 coaching sessions
- **Face-to-face and virtual counseling** — up to 3 visits per employee/household member per issue, per year
- **Bereavement** — support available through telephonic or face-to-face sessions; online resources available on EAP website
- **EAP website resources** — includes webinars, podcasts, articles, videos, FAQs, etc.; additionally, individuals can chat online with an EAP consultant
- **College planning resources** — expert assistance in finding the right college that fits your child academically, socially and financially, provided by College Planning USA

- **Work-life assistance and resources**
- **Work-life services** — unlimited 24/7 access to work-life specialists (subject matter experts) in the areas of family and care giving, health and wellness, emotional well-being, daily living, and balancing work and life responsibilities
- **Child and elder care referral** — unlimited telephonic consultation with a work-life specialist (part of Work-life services)
- **Employee discounts** — access to discounts on a large number of products and services, from gym memberships to dental, vision and pharmacy items, entertainment, restaurants, computers, cars, and much more
- **Medical billing negotiation tools** — information and guidance on negotiating medical bills

worklife.uprisehealth.com

Access code: worklife

Phone: 1-800-386-7055
24 hour crisis help available. Regular office hours: Monday-Friday 6am-5pm PST.

Wellness

Take Charge of Your Health & Well-Being

Process Technology offers a voluntary wellness program available to all team members. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve Team Member health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

Earn Monetary Incentive

Team members who choose to participate in the wellness program will receive a monetary incentive that will be applied toward the medical contributions, if enrolled in the Process Technology medical plan. Please see the program requirements below:

Wellness Premium Incentive Requirements

- **Preventive Wellness Exam with your Primary Care Physician (PCP)**
  - Knowing your numbers, glucose, HDL, LDL, total cholesterol, blood pressure, and weight are important in understanding the state of your physical well-being.
  - Team members are asked to make an appointment with their primary care physician and have their preventive wellness exam completed.
    - Team members will need to take the primary care physician form with them to their scheduled appointment. Please contact Talent Management for your PCP form.
    - **Team members must return the completed, physician signed form, back to Talent Management. *Please contact Talent Management for deadlines*.**
    - Upon receiving your completed form, you will be awarded one point

If your spouse is on the medical plan, we ask that your spouse also make an appointment with their PCP. Both you and your spouse must have a preventive wellness exam in order to receive one point.

- **Non-Nicotine User**
  - Team members must complete the tobacco affidavit stating you whether you are tobacco free or are a tobacco user.
  - The tobacco affidavit will be available for completion during open enrollment.
  - Spouses are asked to complete a tobacco affidavit as well.
  - Team members that are non-tobacco users will be awarded one credit.
  - Team members and spouses that are non-tobacco users will be awarded one credit.

Reasonable Alternative Standard

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all team members. If you think you might be unable to meet a standard for a tobacco reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact Talent Management and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.]

You may request a reasonable alternative by contacting your Talent Management department.

Diabetes & Health Management

Free Confidential Health Coaching Available to You and Your Family

Working with a health coach can be expensive, but you're in luck. Your employer is providing you and your family Free, confidential access to Certified Health Coaches.

www.gemcorehealth.com/enroll

Take the next step in your health journey and get the support you need from a health coach who will help you assess your needs, establish goals, build a personalized plan, and support you along the way!

You and your family can get help for:

- ☑ Nutrition and Weight Loss
- ☑ Fitness
- ☑ Diabetes (Includes supplies)
- ☑ Hypertension
- ☑ Cholesterol
- ☑ and More!

It's simple, it's free, and it's confidential! Enjoy these benefits at no cost to you, from the comfort of your home.

Here's How It Works:

1. Visit www.gemcorehealth.com/enroll, scan QR code or call 1-888-423-5220 to enroll.
2. Your coach will then assess your needs and help you establish your goals and build a personalized plan just for you.
3. Your coach will provide support and coaching to help you reach your goals, and will provide supportive resources along the way.
4. Your coach can be reached via phone, email, text, and through our secure online patient portal so you can talk to your coach how and when you need to.

PROCESS TECHNOLOGY

On-Goal Diabetes and Disease Management is a paid benefit provided by your employer and administered by GEMCORE, a Family of Companies.
v.01312023

On-Goal

Diabetes Management

with diabetes supplies

ENROLL AT NO COST TO YOU

Living with Diabetes Just Got Easier!

Whether you or your dependents are newly diagnosed or have lived with diabetes for years, **On-Goal Diabetes Management** *can help you take control.*

Nutrition, daily activity, and blood glucose monitoring are all part of effectively managing your diabetes.

Together, we will help you develop a personalized, one-on-one plan tailored to help motivate, educate, and support your daily lifestyle while better managing your diabetes.

On-Goal Diabetes Management is a benefit provided by your employer and administered by GEMCORE.

BENEFITS OF ENROLLING:

One-on-one monthly health coaching	Name-brand diabetes supplies
Supplies shipped on-time, every-time	Direct-to-home delivery

**Available diabetes supplies, amount of supplies and monthly coaching requirements are established by your employer.*

> Enrollment in the Diabetes Management Program has saved my life. When I started, I was confused, with an A1C of almost 15. When we ended, I was below 7, achieving a 6.8 A1C, which was our goal.
>
> *- Diabetes Management Program Member*

GEMCORE™
A FAMILY OF COMPANIES

V.11062020

Getting started is easy! Enroll today!

Call 1-888-423-5220 or visit:
www.gemcorehealth.com/enroll

On-Goal

Health and Wellness Management Program

ENROLL AT NO COST TO YOU

Personalized Approach for Personalized RESULTS!

At times, we know maintaining your health can be challenging, but enrolling in On-Goal is one step in the right direction.

Talk to your dedicated Registered Dietitian (RD) from the comfort of your home on topics such as diabetes, hypertension, weight, stress, and more.

Stop worrying and start living today!

- Set short- and long-term goals to help keep you focused
- Receive expert education from Licensed, Registered Dietitians
- Online account access for tracking your progress and success

> My health coach helped me improve my diet, establish an exercise routine, track my blood pressure, and reduce my cholesterol ultimately improving my overall health.
>
> *- Health Coaching Member*

Our staff of Registered Dietitians' specialties include:

- Prediabetes
- Diabetes
- Hypertension
- Cholesterol
- Obesity
- Stress

On-Goal Health and Wellness Management Program is a paid benefit provided by your employer and administered by GEMCORE.

GEMCORE™
A FAMILY OF COMPANIES

Enroll today! Call 1-888-423-5220 or visit www.gemcorehealth.com/enroll

V.11202020

Plan Notices, Disclosures & Legal Documents

Notice Regarding Wellness Program

If a Constituent Benefit Program listed is a voluntary wellness program available to all employees, it is intended to be administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others

If you choose to participate in the wellness program, depending upon that program, it may include a voluntary health risk assessment that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include blood tests or other diagnostic tests. Please note that this is voluntary, and you are not required to participate in these evaluations or examinations.

In certain wellness programs, employees who choose to participate in the wellness program will receive an incentive that is disclosed to you in the open enrollment information for the Constituent Benefit Program. Although you are not required to complete the assessments or participate in the biometric screening, only employees who do so will receive the incentive. Additional incentives up to the maximums permitted by law, may be available for employees who participate in certain health-related activities or those who achieve certain health outcomes. If so, these will be described in your program materials or otherwise communicated to you.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Plan Administrator listed in your Summary Plan Description. The information from any assessment and any results from your examinations or screenings will be used to provide you with information to help you understand your current health and potential risks and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

Consistent with the disclosures in this Notice regarding the protection of your health and personally identifiable health information, any information gathered in the Constituent Benefit Program that is a wellness program will be confidential. The wellness program may use aggregate information it collects to design a program based on identified health risks in the workplace, but it will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Notice Regarding Wellness Program (continued)

Also, your health information will not be sold, exchanged, transferred, or otherwise disclosed (except as permitted or required by law) to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving any incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is a wellness program nurse, or physician or other health coach staff for purposes of the wellness program. You may inquire about who specifically has access to your information in this regard.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Precautions deemed appropriate will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. Finally, you may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. Any questions should be directed to the Plan Administrator as listed in your Summary Plan Document.

2024 Important Notices & Disclosures

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Notice of Creditable Coverage

Your prescription drug coverage provided under our Health & Welfare Plan is expected to pay out, on average, the same or more than what the standard Medicare prescription drug coverage will pay. This is known as "creditable coverage".

Why This is Important

This information is to help you decide whether or not you want to join a Medicare drug plan. It is important for those eligible for both Medicare and a group health plan to look ahead and weigh the costs, benefits, and participation terms of the various options on a regular, if not annual, basis. Based on individual facts and circumstances some choose to elect Medicare only, some choose to elect coverage under the group health plan only, while some choose to enroll in both coverages. When both are elected, benefits coordinate according to the Medicare Secondary Payer Rules. That is, one plan or the other would *reduce payment* in order to prevent you from being reimbursed the full amount from both sources. Your age, the reason for your Medicare eligibility and other factors determine which plan is primary (pays first, generally without reductions) versus secondary (pays second, generally with reductions).

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 our 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 May You Join A Medicare Drug Plan?

Eligible individuals may join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable 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.

You should also know if you drop or lose your current coverage and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (at least 1%) to join a Medicare drug plan later. Carefully coordinating your transition between plans is therefore essential.
Those who miss these opportunities are generally unable to enroll in a Medicare Part D plan until another enrollment period becomes available.

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 group health plan coverage may or may not be affected as well as dependent coverage. Additional guidance is available at https://www.cms.gov/medicare/prescription-drug-coverage/creditablecoverage?redirect=/creditablecoverage/
which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

2024 Important Notices & Disclosures

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Notice of Creditable Coverage Continued

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

You should also know that if you drop or lose your current coverage with 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 below for further information **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage changes. You also may request a copy of this notice from us at any time.

Contact-Position/Office: Talent Management
Address: 38809 Mentor Avenue, Willoughby, OH 44094
Phone Number: 440-534-8854

For More Information Regarding 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:

1. Visit www.medicare.gov
2. 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
3. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

2024 Important Notices & Disclosures

HIPAA Notice of Privacy Practices

You are receiving this Privacy Notice because you are eligible to participate in an employer sponsored group health plans. The Health Plans are committed to protecting the confidentiality of any health information collected about an individual. This Notice describes how the Health Plan may use and disclose, "protected health information" (PHI). For information to be considered "PHI", it must meet three conditions:

Information is created or received by a health care provider, health plan, employer, or health care clearinghouse; Information relates past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and the information either identifies the individual or provides a reasonable basis for believing that it can be used to identify the individual.

The Health Plan is required by the Health Insurance Portability and Accountability Act (HIPAA) to provide this Notice to an individual. Additionally, the Health Plan is required by law to:

Maintain the privacy of an individual's "protected health information" (PHI) and provide you with the Privacy Notice of its legal duties and privacy practices with respect to an individual's PHI and follow the terms of its Privacy Notice that is currently in effect.

Employees of the plan sponsor who administer and manage this Health Plan may use PHI only for appropriate plan purposes (such as for payment or health care operations), but not for purposes of other benefits not provided by this plan, and not for employment-related purposes of the plan sponsor. These individuals must comply with the same requirements that apply to the Health Plan to protect the confidentiality of PHI.

Uses and Disclosures of Protected Health Information (PHI)

The following categories describe the ways that the Health Plan may use and disclose protected health information. For each category of uses and disclosures, examples will be provided. Not every use or disclosure in a category will be listed. However, all the ways the Health Plan is permitted to use and disclose information will fall within one of these categories.

Treatment Purposes. The Health Plan may disclose PHI to a health care provider for the health care provider's treatment purposes. For example, if an individual's Primary Care Physician (PCP) or treating medical provider refers the individual to a specialist for treatment, the Health Plan can disclose the individual's PHI to the specialist to whom they have been referred so (s)he can become familiar with the individual's medical condition, prior diagnoses and treatment, and prognosis.

Payment Purposes. The Health Plan may use or disclose health information for payment purposes; such as, determining eligibility for plan benefits, obtaining premiums, facilitating payment for the treatment and services an individual receives from health care providers, determining plan responsibility for benefit payments, and coordinating benefits with other benefit plans. Examples of payment functions may include reviewing the medical necessity of health care services, determining whether a particular treatment is experimental or investigational, or determining whether a specific treatment is covered under the plan.

Health Care Operations. The Health Plan may use PHI for its own health care operations and may disclose PHI to carry out necessary insurance related activities. Some examples of Health Care Operations may include: underwriting, premium rating and other activities related to plan coverage; conducting quality assessment and improvement activities; placing contracts; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and business planning, management and general administration of the Health Plan.

Uses and Disclosures of Protected Health Information (PHI) (continued)

To a Business Associate of the Health Plan. The Health Plan may disclose PHI to a Business Associate (BA) of the Health Plan, provided a valid Business Associate Agreement is in place between the Business Associate and the Health Plan. A Business Associate is an entity that performs a function on behalf of the Health Plan and that uses PHI in doing so or provides services to the Health Plan such as legal, actuarial, accounting, consulting, or administrative services. Examples of Business Associates include the Health Plan's Third-Party Administrators (TPAs), Actuary, and Broker.

To the Health Plan Sponsor. The Health Plan may disclose PHI to the Plan Sponsor as long as the sponsor has amended its plan documents, provided a certification to the Health Plan, established certain safeguards and firewalls to limit the classes of employees who will have access to PHI, and to limit the use of PHI to plan purposes and not for non-permissible purposes, as required by the Privacy Rule. Any disclosures to the plan sponsor must be for purposes of administering the Health Plan. Some examples may include: disclosure for claims appeals to the Plan's Benefits Committee, for case management purposes, or to perform plan administration functions.

The Health Plan may also disclose enrollment/disenrollment information to the plan sponsor, for enrollment or disenrollment purposes only, and may disclose "Summary Health information" (as defined under the HIPAA medical privacy regulations) to the plan sponsor for the purpose of obtaining premium bids or modifying or terminating the plan.

Required by Law or Requested as Part of a Regulatory or Legal Proceeding. The Health Plan may use and disclose PHI as required by law or when requested as part of a regulatory or legal proceeding. For example, the Health Plan may disclose medical information when required by a court order in a litigation proceeding, or pursuant to a subpoena, or as necessary to comply with Workers' Compensation laws.

Public Health Activities or to Avert a Serious Threat to Health or Safety. The Health Plan may disclose PHI to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

Law Enforcement or Specific Government Functions. The Health Plan may disclose PHI to law enforcement personnel for purposes such as identifying or locating a suspect, fugitive, material witness or missing person; complying with a court order or subpoena; and other law enforcement purposes.

Other uses and disclosures will be made only with an individual's written authorization or that of their legal representative, and the individual may revoke such authorization as provided by section 164.508(b) (5) of the Privacy Rule. Any disclosures that were made when the individual's Authorization was in effect will not be retracted.

An Individual's Rights Regarding PHI

An individual has the following rights with respect to their PHI:

Right to Inspect and Copy PHI. An individual has the right to inspect and copy health information about them that may be used to make decisions about plan benefits. If they request a copy of the information, a reasonable fee to cover expenses associated with their request may be charged.

Uses and Disclosures of Protected Health Information (PHI) (continued)

Right to Request Restrictions. An individual has the right to request restrictions on certain uses and disclosures of their PHI (although the Health Plan is not required to agree to a requested restriction).

Right to Receive Confidential Communications of PHI. An individual has the right to receive their PHI through a reasonable alternative means or at an alternative location if they believe the Health Plan's usual method of communicating PHI may endanger them.

Right to Request an Amendment. An individual has the right to request the Health Plan to amend their health information that they believe is incorrect or incomplete. The Health Plan is not required to change the PHI but is required to provide the individual with a response in either case.

Right to Accounting of Disclosures. An individual has the right to receive a list or "accounting of disclosures" of their health information made by the Health Plan, except the disclosures made by the Health Plan for treatment, payment, or health care operations, national security, law enforcement or to corrections personnel, pursuant to the individual's Authorization, or to the individual. An individual's request must specify a time period of up to six years and may not include dates prior to May 1, 2010 (effective date of this regulation). The Health Plan will provide one accounting of disclosures free of charge once every 12-month period.

Breach Notification. An individual has the right to receive notice of a breach of your unsecured medical information. Notification may be delayed if so, required by a law enforcement official. If you are deceased and there is a breach of your medical information, the notice will be provided to your next of kin or personal representatives if the plan knows the identity and address of such individual(s).

Genetic Information. An individual's genetic information will not be used for under writing except for long term care plans.

Right to Paper Copy. An individual has a right to receive a paper copy of this Notice of Privacy Practices at any time.

The Health Plan's Responsibilities Regarding an Individual's PHI

The Health Plan is a "covered entity" (CE) and has responsibilities under HIPAA regarding the use and disclosure of PHI. The Health Plan has a legal obligation to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. The Health Plan is required to abide by the terms of the current Notice of Privacy Practices (the "Notice"). The Health Plan reserves the right to change the terms of this Notice at any time and to make the revised Notice provisions effective for all PHI the Health Plan maintains, even PHI obtained prior to the effective date of the revisions. If the Health Plan revises the Notice, the Health Plan will promptly distribute a revised Notice to all actively enrolled participants whenever a material change has been made. Until such time, the Health Plan is required by law to comply with the current version of this Notice.

The complaint will be investigated, and a written response will be provided to the individual within 30 days from receipt of the complaint. A written summary of the complaint and any correction action taken will be filed with the Privacy Officer. The Health Plan will not retaliate against the individual in any way for filing a complaint.

If an individual would like their complaint reviewed by an outside agency, they may contact the Department of Health and Human Services at the following address:

Department of Health and Human Services
The Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 2020

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HIPAA Plan Special Enrollment Notice

If you are declining your enrollment under the Plan, or declining coverage for your spouse or one of your dependents, because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in the Plan if you or your dependents lose eligibility for that other coverage, or if the employer stops contributing toward such other coverage. However, you must request enrollment within 30 days after you or your dependents' other coverage ends, or after the period for which the employer ceased contributing toward such other coverage if such payment applied to your circumstances.

In addition, if you have a new dependent, as a result of your 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, please contact the Plan Administrator listed in the Summary Plan Description or contact the Human Resources department staff for further information.

Genetics Information Notice

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.

Mental Health/Substance Use Disorder Parity

Effective for Plan Years on and after July 1, 2010, benefits under Plans that provide Mental Health Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Newborn's and New Mother's Care Disclosure

This Plan generally does not, consistent with applicable 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, consistent with that same Federal law, this Plan 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, this Plan does not, in accordance with 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).

Women's Health and Cancer Rights Act of 1998 (WHCRA) Annual and Regular Notice

As required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, notwithstanding anything herein to the contrary, the Plan provides coverage for: 1) all stages of reconstruction of the breast on which the mastectomy has been performed; 2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3) prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Plan Administrator listed in the Summary Plan Description, or contact the Human Resources department staff for further information.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility.

2024 Important Notices & Disclosures

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 Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS - Medicaid	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: 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: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
FLORIDA - Medicaid	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA - Medicaid	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
INDIANA - Medicaid	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562
KANSAS - Medicaid	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
KENTUCKY - Medicaid	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
LOUISIANA - Medicaid	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE - Medicaid	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740 TTY: Maine relay 711
MASSACHUSETTS - Medicaid and CHIP	Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa Phone: 1-800-862-4840

MINNESOTA - Medicaid	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 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
NEBRASKA - Medicaid	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA - Medicaid	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE - Medicaid	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY - Medicaid and CHIP	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK - Medicaid	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA - Medicaid	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
NORTH DAKOTA - Medicaid	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA - Medicaid and CHIP	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON - Medicaid	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
PENNSYLVANIA - Medicaid	Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462
RHODE ISLAND – Medicaid and CHIP	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte 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: http://gethipptexas.com/ Phone: 1-800-440-0493
UTAH - Medicaid and CHIP	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669Phone: 1-877-543-7669
VERMONT - Medicaid	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
VIRGINIA - Medicaid and CHIP	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
WASHINGTON - Medicaid	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA - Medicaid	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN - Medicaid and CHIP	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.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, 2023, or for more information on special enrollment rights, contact either:

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

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