2023
BENEFITS GUIDE

accupac

WELCOME TO **ACCUPAC'S ANNUAL OPEN ENROLLMENT!**

Here's where to find ...

Enrollment and Eligibility 3
Aetna Medical Plans 4
Employer's Health Drug Coverage 6
HSA and High Deductible Health Plan FAQs 8
CVS Minute Clinic 10
Teladoc 11
Where Do I Go For Care 12
Aetna Health & Wellness 13
Supplemental Health Benefits 14
Aetna Dental Plan 15
Eyemed Vision Plan 16
Flexible Spending Accounts (FSAs) 17
FSA Store and Mobile App 18
Additional Accupac Benefits 19
Pet Discount Plan 20
Work/Life Employee Assistance Program (EAP) 21
Contacts 22
Notices 23

Accupac is pleased to present your 2023 Open Enrollment information. During Open Enrollment, you can enroll in or make changes to your benefit elections. This Open Enrollment newsletter explains your benefit options available to you and what is changing for the new plan year. Our benefit plan year will be from January 1, 2023 through December 31, 2023.

Each year, Accupac takes a close look at our benefits package to ensure that we offer the best value and quality coverage for you and your family. For the year to come, please make sure to evaluate your needs, learn about your benefit options, and make smart decisions about your health and well-being. We will continue to offer a comprehensive selection of benefits that you and your family can use to protect your health, finances, and future.

A few notes about enrolling in benefits

The choices you make during enrollment will be in effect for the 12-month plan year from January 1, 2023 to December 31, 2023. However, you may make changes during the year if you experience a qualified life event. If you need to report a status change during the year, you will need to contact the Human Resources Department with the necessary changes within 31 days of the event.

Here are some examples of qualifying life events:

- Birth, legal adoption or placement for adoption.
- Marriage, divorce or legal separation.
- Dependent child reaches age 26.
- Spouse gains or loses employment or eligibility with their current employer.
- Death of your spouse or dependent child.
- Spouse or dependent becomes eligible or ineligible for Medicare/Medicaid or the state children's health insurance program.
- Change in residence that changes coverage eligibility.
- Court-ordered change.

Dependent Eligibility

You may enroll your eligible dependents when you enroll yourself. Dependents who are eligible for benefit coverage include:

- Your legally married spouse*
- Your dependent children

** See Spousal Exclusion at right*

Included in the definition of dependent child(ren) are:

- Your naturally born child(ren), legally adopted child(ren), step-child (ren), or court-ordered dependent child(ren) for whom you are the court-appointed legal guardian
- Your dependent child(ren) up to age 26 whether they are a fulltime student or not. Coverage ends at the end of the month following the date they turn 26.
- Your continuously disabled dependent child(ren) [if disabled prior to age 26] who are incapable of self-sustaining employment and dependent upon you for support, regardless of age

Spousal Exclusion

If your spouse is employed with another employer and is eligible for his/her employer's group medical, prescription, dental and vision coverage, your spouse is not eligible to enroll in Accupac's medical, prescription, and dental and vision plans. This exclusion applies regardless of whether the available coverage is contributory or non-contributory. If your spouse does not have coverage available through his/her employer or is unemployed, the spousal exclusion may be waived by submitting a Spousal Coverage Certification.

Dependents may now be covered under the dental plan until age 26.

AETNA MEDICAL PLANS

Accupac is committed to helping you and your dependents maintain your health and wellness by providing you with access to the highest levels of care. We offer you a choice of three medical plan options for 2023:

- **AETNA HEALTH MAINTENANCE ORGANIZATION (HMO) SELECT PLAN**
  Under the Aetna HMO plan, or "Aetna Select" you must select a Primary Care Physician (PCP) to handle all of your care and you are required to obtain a referral to see a specialist. The PCP may be a family doctor, pediatrician, or general practitioner that will provide your care and will refer you to specialists or facilities for treatment when medically necessary. Your PCP will provide routine care for illness, injury, and preventive care such as periodic physical exams, eye exams, well-baby visits, and immunizations. You may change your PCP at any time by calling Aetna Member Services or by accessing Aetna Navigator online. To find a provider search under "Aetna Select."
- **AETNA CHOICE POINT-OF-SERVICE II (POS) PLAN**
  Aetna's Choice POS II Plan gives you the choice of selecting a primary care physician and the option to self-refer when you need specialty care. Each time you need care, you may see your PCP, who will provide basic, routine services and referrals for specialty care. Or you may seek care on your own, without the help of your PCP. Benefits are highest and your out-of- pocket cost lowest when care is provided or coordinated by an in-network provider. To find a provider search under: Aetna Choice POS II (Open Access).
- **AETNA HIGH DEDUCTIBLE HEALTH PLAN (HDHP)**
  Aetna's HDHP Managed Choice Plan is designed to give you more control and responsibility over how you spend — or save your health care dollars. Once the deductible is met, the plan pays 100% for in-network services. Although the HDHP option has a higher deductible, your payroll deductions will be lower. Additionally, you are eligible for an HSA if you are enrolled in the HDHP. You may use the money in your HSA to pay all or a portion of your annual deductible, copayments, coinsurance, or other eligible out-of-pocket costs. Refer to page 6 for more information on how the HDHP and HSA work. To find a provider, search under: Aetna Choice POS II (Aetna Health Fund).

We will continue the health savings account (HSA) which can be paired with the HDHP to help you save on eligible health care expenses.

Aetna offers a large network of health care professionals that provide quality and cost-effective care. To find a participating network provider, visit DocFind online at www.aetna.com.

Accupac will give a $25 Gift Card in 2023 for anyone and their dependents under the age of 18 that receives their Annual Physicals.

Annual physicals are considered preventative and covered at 100% on ALL plans.

A few examples of preventative visits are:
Annual Well Check with your PCP, Mammograms, Colonoscopy, OB-GYN Visit, etc.

Medical Plan Summaries

Side-by-side

	HDHP Managed Choice		HMO Select	Choice POS II	
	You Pay In-network	You Pay Out-of-network	You Pay In-network Only	You Pay In-network	You Pay Out-of-network
Annual Deductible Individual Family	 $2,000 $4,000	 $5,000 $10,000	 $500 $1,000	 $300 $600	 $1,500 $4,500
Referral Required?	No	No	Yes	No	N/A
Out-of-pocket maximum (includes deductible) Individual Family	 $6,350 $12,700	 $10,000 $20,000	 $4,000 $8,000	 $6,600 $13,200	 $10,000 $30,000
Selection of PCP Required?	No	N/A	Yes	No	N/A
Preventive care	$0	40% after ded	$0	$0	50% after ded
Office visit PCP Copay Specialist Copay Mental Health	 20% after ded 20% after ded 20% after ded	 40% after ded 40% after ded	 $30 ded waived $50 ded waived $30 ded waived	 $20 ded waived $40 ded waived $20 ded waived	 50% after ded 50% after ded
Diagnostic Procedures X-Ray Laboratory Complex Imaging	 20% after ded 20% after ded 20% after ded	 40% after ded 40% after ded 40% after ded	 $50 ded waived Covered 100% after ded $100 ded waived	 $40 ded waived Covered 100% after ded $100 ded waived	 50% after ded 50% after ded 50% after ded
Emergency room	20% after ded	20% after ded	$150 ded waived	$150 ded waived	$150
Urgent care	20% after ded	50% after ded	$50 ded waived	$50 ded waived	50% after ded
Inpatient care	20% after ded	40% after ded	$500/day (5 day max) ded waived	$250/day (5 day max) ded waived	50% after ded
Outpatient care	20% after ded	40% after ded	$250 per visit ded waived	$125 per visit ded waived	50% after ded
Teladoc	$47	N/A	$0 ded waived	$0 ded waived	N/A
Durable Medical Equipment	20% after ded	40% after ded	50% ded waived	50% ded waived	50% after ded
Vision Eyewear (once every 24 months)	Up to $100 allowance Exam 0% ded waived	Up to $100 allowance Exam 40% after ded	Up to $100 allowance $50 eye exam	Up to $100 allowance Exam 0% ded waived	Up to $100 allowance Exam 50% after ded

Medical and prescription biweekly employee payroll contributions

Effective Jan. 1. 2023

	HDHP Managed Choice	HMO Select	Choice POS II
Employee	$61.96	$94.39	$119.96
Employee + spouse	$171.94	$238.91	$284.92
Employee + child(ren)	$138.20	$198.06	$238.47
Family	$232.44	$327.40	$389.74

Go Generic! Keep You and Your Wallet Healthy

1. **What are generic drugs?**
   Generic drugs are prescription medications that have the same active ingredients, dosage amounts, strength, safety, and quality as brand-name prescription medications.
2. **Are generic drugs just as safe as brand-name drugs?**
   Yes. Laboratories that produce generic drugs must meet the same high FDA standards as the facilities of brand-name drugs, and all generic drugs are FDA-approved to be therapeutically equivalent to brand-name drugs.
3. **Why are generic drugs less expensive?**
   When a new medicine is invented, a patent is filed so that no other company may reproduce that drug. While the patent is current, companies can charge a much higher price for the drug because there is no competition. In addition, companies often spend large amounts of money for advertising and promotion, further increasing the cost of the brand name medication.

   When a medication's patent expires, other companies may produce this drug, creating generic medications. Due to increased competition, and because these other companies rarely spend money on advertising, the price of the generic drug is significantly lower.
4. **What is different about generic?**
   The appearance of brand-name drugs is protected by law, so generic drugs will have different shapes, flavors, and/or colors. However, since the active ingredients are the same, they will work the same way in your body as the brand-name drug.
5. **Does every brand-name drug have a generic drug equivalent?**
   No. Pharmaceutical companies have a patent on their brand name medications, so new drugs will not have a generic equivalent until the patent expires.
6. **What if my brand-name drug is not available in generic form?**
   Even if your brand name drug is not available in generic form, there may be a different generic drug that could work just as well. Ask your doctor if a therapeutic alternative might be right for you. A generic therapeutic alternative is the equivalent for a different brand-name drug and treats your condition using a different active ingredient. If your doctor agrees, you can feel confident about using the generic therapeutic alternative and feel good about saving money too!

CVS PRESCRIPTION DRUG COVERAGE

When you enroll in an Accupac medical plan, you automatically receive prescription drug coverage through the CVS Pharmacy. Your Prescription drug plan will be administered through CVS Employers Health effective January 1, 2023. There is a dedicated Customer Care team available 24 hours a day, seven days a week. They can be reached at 844.371.0844.

	HDHP Managed Choice		HMO Select	Choice POS II	
Retail (30-day Supply)	In-network	Out-of-network	In-network Only	In-network	Out-of-network
Tier 1 - Generics	$15 after ded	40% of submitted cost after the applicable preferred copay	$15 ded waived	$15 ded waived	50% of submitted cost after the applicable preferred copay
Tier 2 - Preferred	$35 after ded		$35 ded waived	$35 ded waived	
Tier 2 - non-preferred	$50 after ded		$50 ded waived	$50 ded waived	
Mail Order (90-day Supply)	In-network	Out-of-network	In-network Only	In-network	Out-of-network
Tier 1 - Generics	$30 after ded	N/A	$30 ded waived	$30 ded waived	N/A
Tier 2 - Preferred	$70 after ded		$70 ded waived	$70 ded waived	
Tier 2 - non-preferred	$100 after ded		$100 ded waived	$100 ded waived	

Save Money - Use Mail Order!

The prescription plan also includes the CVS Caremark Mail Service Pharmacy, which allows you to purchase a 90-day supply of medications you take on an ongoing basis (known as maintenance drugs). You don't have to worry about making a trip to the pharmacy every 30 days, and 90-day supplies typically cost less than three separate 30-day supplies.

To enroll, call Customer Care at 844-371-0844 or register at www.caremark.com/startnow and follow the guided steps to request a prescription.

Fill your prescriptions on time

CVS offers convenient options for filling your medication so you never run out. Choose the one that's right for you.

- Pick up your refills at any CVS Pharmacy®. With more than 9,900 locations, there's always one nearby
- Have refills delivered to your door. You'll pay just one copay* for a 90-day supply with no-cost shipping from CVS Caremark® Mail Service Pharmacy
- Let us manage your refills. Sign up for automatic refills at Caremark.com or in our mobile app

CVS digital tools make it easy to manage your health whenever – and wherever – you like. You can look for saving opportunities, stay on top of your prescriptions and more. Here's how CVS digital tools can help you every day.

Stay in the loop.

Sign up to get email or text messages about your prescriptions, ways
to save, status updates and more.

Refill fast.

Request refills quickly and keep track of prescriptions for your family in one convenient place. See how close you are to meeting your deductible and out-of-pocket cost maximum anytime.

Want more convenience?

With delivery, you have one less thing to worry about. Your 90-day supplies will arrive at your door from CVS Caremark® Mail Service Pharmacy.

Like to save?

Filling your Rx in 90-day supplies usually comes with savings. Plus, there's no extra cost for shipping.

Explore Rx savings options.

Find out if your Rx is covered or if you could pay less for it. And see if options like Rx delivery by mail or changing to a generic medication can save you money.

CVS Specialty provides specialized care and support along with your medication for complex conditions (such as rheumatoid arthritis, multiple sclerosis, HIV and cancer).

You are given a CVS Specialty CareTeam led by pharmacists and nurses to support you 365 days a year. They'll show you how to take your medication correctly, help you manage side effects and stay on track. Helpful resources are available at CVSspecialty.com/EducationCenter. **A choice of pick up at CVS Pharmacy® or home delivery at no extra cost.**

Save time, keep costs down and stay on top of your prescriptions. Do it all at Caremark.com and the CVS Caremark mobile app.

- Find a network pharmacy to keep medication costs as low as possible
- See if a medication is covered to get the most affordable option
- Compare drug costs to see where you can save
- Sign up to get email or text messages about your prescriptions and more
- Request refills and keep track of prescriptions for your family

HSA AND HIGH DEDUCTIBLE HEALTH PLAN

FREQUENTLY ASKED QUESTIONS

If you elect the HDHP, you will be provided with the opportunity to enroll in a health savings account that you can use in conjunction with the consumer-driven health plan. Below are frequently asked questions and answers surrounding the HDHP and HSA.

What is an HSA?

The HSA is a tax-favored account used in conjunction with an HSA-compatible health plan. The HSA allows you to contribute funds on a pre-tax or tax-deductible basis, which you may use to pay for eligible medical, dental and vision expenses. Eligible expenses are defined by the IRS Publication 502 on www.irs.gov. If you don't use all the money in your account, the balance rolls over to following years. Those dollars continue to earn interest — and continue to be available for medical expenses year after year.

Who is eligible to establish an HSA?

You are eligible to open an HSA provided you have met the following criteria:

- Must be enrolled in a HDHP and not also be covered by another health plan that is not a HDHP
- Not listed as a dependent on another person's tax return
- Not be enrolled in Medicare

How is an HSA-eligible HDHP plan different than a traditional health plan?

Health insurance premiums are lower than the cost of traditional health insurance. The average premium reduction is 20-30% as compared to traditional health insurance.

How can an HSA save me money?

The principal balance may be held in a guaranteed fixed interest rate investment option. Interest is tax-free and higher than in many other types of savings accounts. Distributions for qualified expenses are also tax-free.

Can I still go to my regular doctor?

Yes. With an HSA eligible HDHP, you are free to use any in-network doctor and hospital you choose. With an HSA eligible HDHP, you will still have an insurance ID card, and you will need to make sure that you present this card anytime you go to the doctor or pharmacy. This will ensure that you always get any network discounts available to you, and your medical provider will be able to file a claim with Aetna so any out-of-pocket amounts will be applied to your deductible.

How does it work?

Since an HSA is a tax advantaged account, you will need to be able to prove that money you spend from your HSA is for eligible medical expenses. Remember to save your receipts for all of your HSA expenses. You are not required to submit your receipts when you use your funds, but you will need them if you are ever audited by the IRS. You can use your HSA debit card to pay for expenses when you are billed, or you can pay out-of-pocket and reimburse yourself at a later date.

Will I have to pay whatever the doctor charges me and how will I be able to obtain a timely reimbursement?

In most cases, doctors are generally encouraged to wait for the insurance company to process your claim before they request payment from their patients. You should also wait for your insurance to process your claim before making any payment to the providers. Aetna negotiates a price with its network doctors which is usually much less than what the doctor typically charges, and that savings is passed on to you.

Does having an HSA affect my participation in a health care FSA?

If you are enrolling in the HDHP and currently have an FSA, you cannot contribute to an HSA at the same time. These are IRS rules and can be referenced at www.irs.gov.

How much can be in the HSA account?

For 2023, you can save up to the maximum contribution limit of $3,850 for an individual HSA health plan and $7,750 for a family HSA health plan each year.

If you are married and your spouse has a family HDHP, then both spouses are determined to have family coverage. This is true even if one spouse has a family plan and the other has a self-only plan. Each spouse may have an HSA, and together you may contribute up to the family limit. You may not each contribute up to the family limit.

If you are age 55 and older you may contribute an additional $1,000 to your HSA. This is a "catch up" contribution that may be made each year that you are eligible for a HDHP. You may no longer contribute once you enroll in Medicare.

Is the HSA account portable?

Yes. You keep your HSA even if you change jobs, change medical coverage, retire or make other life changes.

Who Administers the HSA?

Aetna partners with PayFlex to manage your HSA. When you enroll in the HDHP, you will need to open an HSA through PayFlex. You will receive a PayFlex card in the mail which will help make it easy for you and your family members to pay for eligible expenses with the funds in your account.

There is a $4.20 Monthly Account Maintenance Fee associated with your PayFlex HSA.

You can access your account online at www.PayFlex.com, where you can view educational materials, forms, frequently asked questions and eligible expense listings. You will need to register your first time logging in. PayFlex customer service representatives are also available to help you with any questions. To speak with a representative, call the toll free number at 1-844-PAYFLEX.

CVS MINUTE CLINIC

Sometimes things just happen. Your kid develops flu symptoms after your primary care office has closed for the day. You step on a tack over the weekend. We get it, things happen, and when they do, you want to be able to access care at a price you can afford. That's why we're offering a new perk to eligible Aetna members: access to all covered MinuteClinic services at no cost to you, or low cost to you, based on your plan design.

What is MinuteClinic?

- MinuteClinic is a walk-in clinic inside select CVS Pharmacy® and Target stores and is the largest provider of retail health care in the United States, making it easy to access care in your neighborhood.
- MinuteClinic offers a broad range of services to keep you and your family healthy. MinuteClinic health care providers treat and diagnose a variety of illnesses, injuries and conditions. They can also write prescriptions, when medically appropriate.
- The MinuteClinic program is fully integrated into Aetna's web and mobile tools and its provider search functionality. Members can use the provider search to lookup nearby MinuteClinic locations and estimate the cost of services compared to other sites of care. When members perform a search based on specific conditions, MinuteClinic locations will be highlighted when appropriate.

How do I use MinuteClinic

It's as simple as going to your local physician and receiving care. Your covered family members can take advantage of this benefit, too. You can walk in or schedule appointments online beforehand. And for even more convenience, you can pick up your prescription on-site. MinuteClinic is open 7 days a week, including evenings and weekends.

For your best health, we encourage you to have a relationship with a primary care physician or other doctor. Tell them about your visit to MinuteClinic, or MinuteClinic can send a summary of your visit directly to them.

Note: Eligible Aetna members who enroll in qualified high-deductible health plans will receive lower-cost care for covered minor illness and injury services provided at MinuteClinic and can receive preventive services at no cost share. However, in order to receive no-cost care on all covered services, they will need to first meet their deductible. Once the deductible has been met, those members will be able to access covered MinuteClinic services at no cost share.

TELADOC

All Accupac Aetna members will automatically be enrolled in Teladoc. Teladoc gives you 24/7/365 access to a doctor through the convenience of phone or video consults. It's an affordable option for quality medical care.

Why Should I Use Teladoc

- Talk to a doctor anytime, anywhere you happen to be
- Receive quality care via phone or online video
- Prompt treatment - average call back in 16 minutes
- A network of doctors that can treat children of any age
- Secure, personal & portable electronic health record (EHR)
- No limit on consults

When Can I Use Teladoc?

- When you need care now
- If your doctor is unavailable
- If you're considering the ER or urgent care center for a non-emergency issue
- On vacation, on a business trip, or away from home
- For short-term prescription refills

Get the Care You Need

Teladoc doctors can treat many medical conditions, including

- Cold & flu symptoms
- Allergies
- Bronchitis
- Skin problems
- Respiratory infection
- Sinus problems
- And more!

Accupac Employee Testimonial:

When I called Teladoc for the first time, I couldn't believe how easy it was. I was home sick with a toddler and going to the doctor's office wasn't ideal since it was flu season. I called, spoke to a doctor, and was diagnosed over the phone. The doctor then called me in a prescription. The process couldn't have been easier.

Cost Summary

	HDHP Managed Choice	HMO Select	Choice POS II
General Medicine	Deductible Then No Charge	No Charge	No Charge
Behavioral Health	Deductible Then 20%	$50 Copay	$40 Copay
Dermatology	Deductible Then 20%	$50 Copay	$40 Copay

You can see a Psychiatrist and Dermatologist through Teladoc!

Talk to a doctor anytime at no cost

- Teladoc.com/Aetna
- 1.855.Teladoc (835-2362)
- Facebook.com/Teladoc
- Teladoc.com/mobile

**$0 copay only applies to the HMO Select and Choice POS plans. if you are enrolled in the HDHP, please bring proof of your visit to HR and you will be reimbursed the amount of visit*

WHERE DO I GO FOR CARE?

If you're faced with a sudden illness or injury, making an informed choice on where to see 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. If you suddenly fall ill or become injured, how can you determine which facility is most appropriate for your condition?

Doctor's Office

When you have any medical concerns, your primary doctor can oversee your care and provide routine services.

- Routine check-ups
- Immunizations
- Preventative services
- Manage your overall health

Teladoc

You have access to Teladoc from anywhere - home, work, or on the road - and let the doctor come to you! Teladoc doctors diagnose nonemergency medical problems, recommend treatment, and can even call in a prescription to your pharmacy of choice, when necessary.

- Respiratory infections
- Ear infections
- Urinary tract infections
- Allergies
- Colds and flu
- Sore throat

Urgent Care

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.

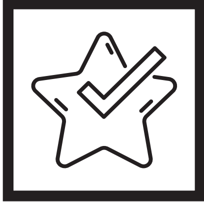
- Controlled bleeding or cuts that require stitches
- Diagnostic services (x-rays, lab tests)
- Ear infections
- High fever or the flu

Emergency Room

The emergency room (ER) is equipped to handle life-threatening injures and illnesses and other serious medical conditions. Patients are seen according to the seriousness of their conditions in relation to other patients.

- Compound fractures
- Deep knife or gunshot wounds
- Moderate to serious burns
- Poisoning or suspected poisoning
- Seizures or loss of consciousness
- Serious head, neck or back injuries

Choosing the appropriate place of care will not only ensure prompt and adequate medical attention, but will also help reduce any unnecessary expenses. Although urgent care centers are usually more cost-effective, they are not a substitute for emergency care.



AETNA HEALTH & WELLNESS

There are added-value benefits available through your medical plans that are designed to encourage healthy behaviors. Additionally, discounts are available on products and services to help improve your health and save you money. Visit www.aetna.com for access to the following programs:

Through Aetna's Health and Wellness Programs, you can receive discounts on:

- Gym memberships
- Home exercise products and equipment
- Eye care, eyewear, and accessories
- LASIK eye surgery
- Over-the-counter vitamins
- Massage therapy
- Chiropractic visits
- Acupuncture
- Dietetic counseling
- Hearing aids and exams
- Weight Management Programs
- Aetna Natural Products and Services℠
- Vitamins
- Water Piks

Programs to help manage your health

Acupuncture: This is a covered benefit under the Accupac medical plan.

Simple Steps: Includes programs for smoking cessation, stress management, dealing with depression, nutrition and diet information, as well as an on-line Health Risk Assessment.

Informed Health Line: – You have 24/7/365 access to the Aetna online medical database for health information and to speak with a registered nurse for questions on health issues.

The following programs add value to your plan and are yours at no additional cost just because you're an Aetna member:

- National Medical Excellence Program
- Fitness Program
- Vision Programs
- Alternative Health Care Programs
- Informed Health Line®

Get Active!℠: Features an online fitness and nutrition tracker, team-based challenges, social networking, emails, newsletters, activity tracking, full reporting capabilities, and the option to purchase a welcome kit that includes a pedometer.

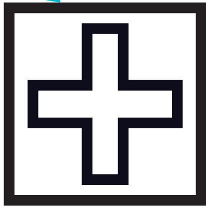
Get Active! is a year-round program that offers inviting, seasonal challenges to keep people moving and motivated through the year. It starts with an eight-week team challenge and continues with other shorter challenges. All are supported by the program's social networking component, which drives engagement and helps create lasting behavior change.

Member Payment Estimator: Log on to Aetna Navigator to find out what a medical service will cost before you make the appointment. This tool will let you compare costs for up to three local providers or facilities at a time and provide you with a real-time cost estimate based on your plan.

Aetna Member Website: As an Aetna member, you have access to Aetna Member Website, your online resource for personalized benefits and health information. Aetna members can take full advantage of the interactive website to complete a variety of self-service transactions online. You can access the site 24 hours a day, 7 days a week—from wherever you have Internet access.

Aetna Member Website helps you make the most of your benefits plan. You can:

- Review who is covered on your plan
- Obtain instant eligibility information or a replacement member ID card
- Check the status of a medical or pharmacy claim
- Research the price of a drug and learn if there are less-costly alternatives
- Price a medical procedure
- Contact Aetna Member Services



SUPPLEMENTAL HEALTH BENEFITS

Aetna Critical Illness Insurance

Critical Illness Insurance provides a cash benefit when a covered person is diagnosed with a covered critical illness or event after coverage is in effect.

	Benefit
Employee	$10,000 or $20,000
Spouse	50% of employee face amount
Children	50% of employee face amount

Aetna Hospital Care Coverage

Hospital care coverage provides a benefit according to the schedule below when a covered person includes a hospital stay resulting from a covered injury or covered Illness.

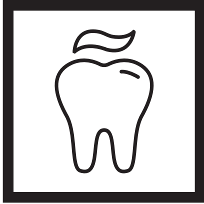
	Benefit
Admission	$1,000
Hospital Daily Stay	$100
ICU Daily Stay	$200
Substance Abuse Daily Stay	$100
Rehabilitation Unit Daily Stay	$50

Register on the My Aetna Supplemental app or on the member portal at Myaetnasupplemental.com to view plan documents, submit and track claims, and sign up for direct deposit.

Aetna Accidental Injury Insurance

Accidental Injury coverage provides a benefit according to the schedule below when a covered person suffers covered Injuries or undergoes a broad range of medical treatments or case resulting from a covered accident.

	Benefit
Initial & Emergency Care	
Ground Ambulance / Air Ambulance	$300 / $1,500
Emergency Room / Hospital	$150
Diagnostic Exam (x-ray or lab)	$50
Physician Office Visit	$150
Follow-up Care	
Emergency Room / Hospital	$50
Physician Office Visit	$50
Therapy services: Speech, occupational, physical therapy or cognitive rehabilitation	$25
Fractures and Dislocations	
Per Covered Surgically repaired fracture	Up to $8,250
Per Covered non-Surgically repaired fracture	Up to $4,125
Chip Fracture (percent of fracture benefit)	25%
Per Covered Surgically repaired Dislocation	Up to $6,000
Per Covered Non-Surgically repaired Dislocation	Up to $3,000
AD&D and Paralysis	
Accidental Dismemberment	Up to $10,000
Paralysis	Up to $10,000



AETNA DENTAL PLAN

Our dental plan is offered through Aetna and you have access to the PPO/PDN with PPO II Extend network of dentists.

Under Aetna's DPPO plan, you have the option of going in or out of the Aetna Dental network of providers. The network is extensive and the benefits are similar in- or out-of-network; however, your benefit level is higher if you use in-network providers.

In-network dentists are required to accept the Aetna Dental negotiated fee as payment in full. If you decide to use a nonparticipating dentist, your out-of-pocket expenses may be more, since you will be required to pay for any difference between the dentist's usual fee and Aetna's payment for the approved service. Preventive Care is covered at 100% in or out of the network (subject to plan limits).

To find a participating dentist, visit the Aetna website at www.aetna.com/find-a-doctor. Then search under "Find a Dentist."

Dental plan summary

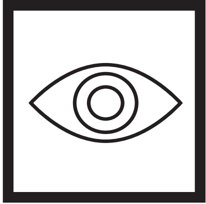
Aetna Dental	DPPO	
Feature/Service	In-network	Out-of-network
Annual Deductible Individual Family	$50 $150	
Annual Maximum per Person	$1,500	
Preventive and Diagnostic	0%	0%
Basic Services	20%*	20%*
Major Services	50%*	50%*
Endodontic/Periodontal	20%*	20%*
Orthodontia (Eligible dependent children up to age 19)	50%	50%
Orthodontia Lifetime Maximum	$1,000	

**Subject to annual deductible*

Dental biweekly employee payroll contributions

Aetna Dental	
Single	$9.33
Employee + Spouse	$28.61
Employee + Child(ren)	$28.61
Family	$28.61

Accupac will give a $25 gift card to any employee that receives their annual dental cleaning in 2023!



EYEMED VISION PLAN

EyeMeds's vision care benefits include coverage for eye exams, standard lenses and frames, contact lenses and discounts for laser surgery. The vision plan is built around a network of eye care providers, with better benefits at a lower cost to you when you use providers who belong to the EyeMed network. When you use an out-of-network provider, you will have to pay more for vision services. Once enrolled, you will receive an ID card in the mail. ID cards can also be printed at www.eyemedvisioncare.com.

Eye exams can tell your doctor a lot about your overall health. It's important to schedule regular exams to help detect significant medical conditions before they become serious.

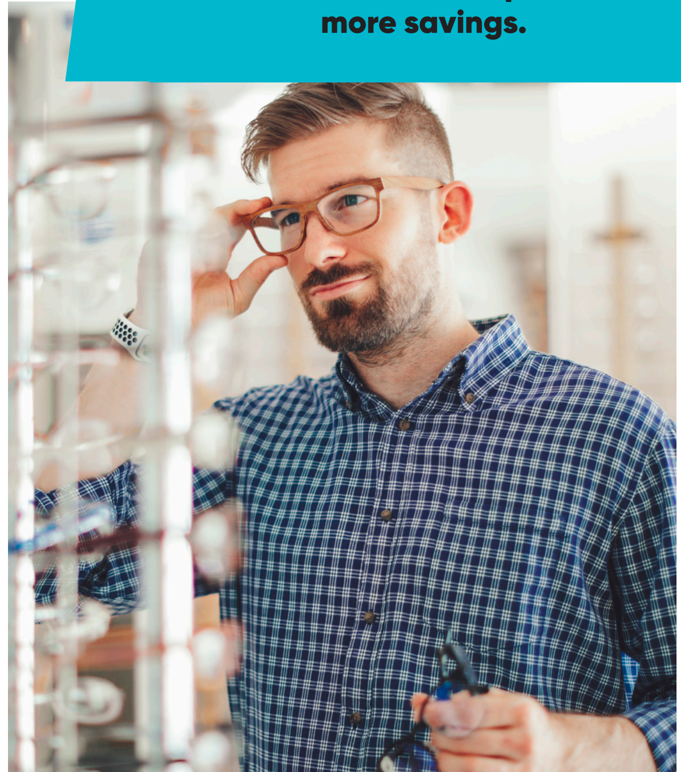
Vision plan summary

Eyemed Vision	Insight Network	
Feature/Service	In-network	Out-of-network
Exam	Once every plan year	
Frames	Once every other plan year	
Exam at PLUSProvider	$0 Copay	Up to $40
Exam	$10 Copay	Up to $40
Frames at PLUS Provider	$0 copay; 20% off balance over $170 allowance	Up to $84
Frames	$0 copay; 20% off balance over $120 allowance	Up to $84
Lenses	Once every plan year	
Single Vision	$25 copay	Up to $30
Bifocal	$25 copay	Up to $50
Trifocal	$25 copay	Up to $70
Contact Lenses	Once every plan year	
Contacts	$0 copay; 15% off balance over $120 allowance	Up to $84

Save even more with PLUS Providers!

PLUS Providers are already in-network so the extra perks are built right into your vision benefits.

$50 Additional frame allowance from PLUS Providers. No promo codes, no coupons, no paperwork, no claims. The same vision care, plus a little more savings.



Vision biweekly employee payroll contributions

Eyemed Vision	
Single	$2.09
Employee + Spouse	$3.96
Employee + Child(ren)	$4.17
Family	$6.13

FLEXIBLE SPENDING ACCOUNTS (FSA)

PayFlex will continue to administer the Flexible Spending Account options for the 2023 plan year. You are able to enroll in the FSA even if you do not enroll in Accupac's Medical or Dental plans. Flexible Spending Accounts (FSAs) are an easy and convenient way to get more out of your paycheck. It allows you to set aside a predetermined amount of your pre-tax dollars to cover certain out-of-pocket expenses as they occur throughout the benefit plan year. Since an FSA is a tax advantaged account, you will need to be able to prove that money you spend from your FSA is for eligible medical expenses. Remember to save your receipts for all of your FSA expenses.

Health Care Flexible Spending Account

A Health Care FSA can reimburse you for eligible medical and dental expenses, up to the amount you contribute for the plan year. Your Health Care FSA lets you pay for qualified medical and dental care expenses not covered by your insurance plan with pre-tax dollars. The expenses must be primarily to alleviate a physical or mental defect or illness, and be adequately substantiated by a medical practitioner. For example, cash that you now spend on deductibles, copayments or other out-of-pocket medical expenses can instead be placed in the Health Care Spending Account, pre-taxed. The maximum amount you can contribute to the Health Care FSA is $3,050.*

**Subject to change per IRS guidelines*

Dependent Care Flexible Spending Account

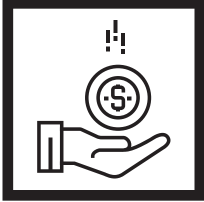
If you need child care for your dependents to allow you or your spouse to work or attend school full-time, you can open a dependent care FSA. This allows you to be reimbursed on a pretax basis for child care. You can contribute up to $5,000 ($2,500 if married and file individual tax return) for the Dependent Care FSA for children under age 13 and for disabled adults in your care.

If you elect to contribute to the Dependent Care FSA, you may be reimbursed for:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

Remember: Use it or lose it

Use all your contributions each plan year because no funds can be carried over to the next year.



FSA STORE & MOBILE APP

The FSA Store is a great educational and retail site that stocks thousands of FSA eligible products. Each product is clearly marked on the site to eliminate confusion about which products require a prescription and which do not. You can shop for eligible items such as bandages, vitamins, and thousand of products in between. You can also search for an eligible provider to find eligible services from dermatologists to ophthalmologist near you.

You can visit FSA Store's Learning Center for answers to all of your FSA-related questions. The informative site is available to make sure you are aware of the many positive FSA benefits available to you.

The goal of Accupac is to help you make the most of your Flexible Spending Account, and with the many features of the FSA Store, we are confident that we can make this benefit simple and rewarding for you.

Visit the FSA Store at www.fsastore.com.

PayFlex Mobile app

With our free PayFlex Mobile app, you can easily access your account information in the palm of your hand. Simply "tap" to:

- Check your account balance and view account activity
- View your account alerts
- Access the Eligible Expense Scanner to verify if an item is an eligible health care expense
- Review a list of common eligible expense items
- Pay your providers directly from your account
- Take pictures of receipts and pay yourself back for eligible expenses
- Submit a claim

What's new with the PayFlex Mobile app?

- PayFlex's Eligible Expense Scanner makes it easy for you to scan an item barcode to determine if it's an eligible health care expense.
- Enhanced security and complimentary fraud protection.

Download now!

- You can download the app from your mobile device's app store.
- The app is supported by the following devices:
  - iOS version 10 or above on iPhone® 5S, iPad Air®, iPad Mini® 2 or newer models
  - Android version 4.4 (Kitkat) or above on phones or tablets
- There's no fee to download the app. Anyone with a PayFlex account can use it for free.

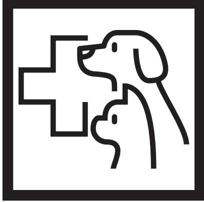
ADDITIONAL ACCUPAC BENEFITS

During this annual enrollment period, you may also enroll in, or change your elections for the following Accupac benefits:

- Supplemental life insurance for you (Proof of Good Health may be required for any new amounts elected or waived when first eligible)
- Life insurance for your dependents (Proof of Good Health may be required for any new amounts elected or waived when first eligible)

The following benefits are provided to all Accupac employees as part of your total compensation/ benefits package. Your enrollment is not required for these benefits below:

- Basic Life/AD&D Insurance (Accupac-paid)
  - Accupac provides all employees with basic life coverage of 1x annual salary to a maximum benefit of $250k.
- Disability Insurance (Accupac-paid)
  - Accupac provides long and short term disability coverage to all employees at no additional cost to you.



PET DISCOUNT PLAN

You can enroll in pet insurance through Pet Benefit Solutions. Your pets are part of your family, and you'll do anything to keep them happy and healthy. But with the cost of pet care on the rise, it isn't always easy.

That's why we offer Total Pet Plan, which makes pet care more affordable. Enroll in Total Pet and get the same high-quality products and services your pets are used to, just at a lower price!

The plan includes:

- Discounts on products & Rx
- Discounts on veterinary care
- 24/7 Pet telehealth
- Lost pet recovery service

Make sure your vet partners with Pet Benefit Solutions to receive discounts. To find a participating vet, visit petbenefits.com or call (800)-891-2565.

To enroll, use Accupac's specific link: petbenefits.com/land/accupac.

WORK/LIFE EMPLOYEE ASSISTANCE PROGRAM (EAP)

Work/Life

Health Advocate is the leading health care advocacy and assistance program nationwide. This benefit is available to you, your spouse, dependent children, parents and parents-in-law. Health Advocate assists with services ranging from health care and insurance-related issues to providing one-on-one support for improving your health and well-being. Registered nurses, medical directors and benefits and claims specialists are available to help give you peace of mind in navigating the health care system. Speak to a Health Advocate representative to:

- Find the best doctors, dentist, hospitals and other health care providers anywhere in the country.
- Expedite appointments including hard-to-reach specialists and arrangements for specialized treatments and tests.
- Help resolve insurance claims; negotiate billing or payment arrangements.
- Assist with eldercare such as finding adult daycare, assisted living and other related issues facing parents, parents-in-law.
- Obtain unbiased health information about complex medical conditions to help you make informed decisions.
- Assist in the transfer of medical records such as x-rays and lab results.
- Work with insurance companies to obtain appropriate approvals for needed services.
- Help you make informed decisions with researching conditions and treatment options, and facilitate second opinions.

Employee Assistance Program (EAP)

You can call Health Advocate's toll-free number for confidential, short-term telephonic resolution services, or up to five in-person professional counseling sessions for a full range of emotional, family and work-related issues. If needed, you can be referred to ongoing treatment or special care. Use Health Advocate's EAP to talk to a certified counselor about:

- Stress, Depression, Anxiety
- Marital relationships, family/parenting issues
- Work conflicts
- Drug/Alcohol Abuse
- Financial Issues
- Legal Concerns

Please Note: Health Advocate does not replace medical insurance. This benefit is available to all Accupac employees regardless if you are enrolled in Accupac's benefits.

How to Reach a Health Advocate Professional

Call 866-695-8622 or visit the website at www.HealthAdvocate.com for more information. Health Advocate can be accessed 24 hours, 7 days a week. Normal business hours are Monday – Friday between 8 a.m. and 9 p.m. EST. After hours and during weekends, on call staff are always available for assistance with issues that need to be addressed during non-business work hours.

CONTACTS

Medical
Aetna

Website: www.aetna.com
Customer service: 800.843.3661
or call the number on the back
of your card

Pharmacy
CVS

Website: www.Caremark.com
Customer service: 844.371.0844

Dental
Aetna

Website: www.aetna.com
Customer service: 800.843.3661

Vision
EyeMed

Website: www.eyemed.com
Customer service: 866.939.3633

Health savings account (HSA)
Payflex

Website: www.payflex.com
Customer service: 844.729.3539

Flexible spending account (FSA)
PayFlex

Website: www.payflex.com
Customer service: 844.729.3539
Fax: 888.238.3539

Life and AD&D Insurance
Lincoln Financial Group

Website: www.lincolnfinancial.com
Customer service: 800.423.2765

Disability
Lincoln Financial Group

Website: www.lincolnfinancial.com
Customer service: 800.423.2765

Employee Assistance Program
Health Advocate

Website: www.healthadvocate.com
Customer service: 866.695.8622

Health Assistance
Health Advocate

Website: www.healthadvocate.com
Customer service: 866.695.8622

Pet Insurance
Pet Benefit Solutions

Website: www.petbenefits.com
Email: info@petbenefits.com
Customer service: 888.913.7387

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.

Accupac

HEALTH PLAN NOTICES

TABLE OF CONTENTS

1. Medicare Part D Creditable Coverage Notice
2. HIPAA Comprehensive Notice of Privacy Policy and Procedures
3. Notice of Special Enrollment Rights
4. General COBRA Notice
5. Notice of Right to Designate Primary Care Provider and of No Obligation for Pre-Authorization for OB/GYN Care
6. Women's Health and Cancer Rights Notice
7. Michelle's Law Notice
    - This notice is still required when a health plan permits dependent eligibility beyond age 26, but conditions such eligibility on student status. Further, the notice is still necessary if the plan permits coverage for non-child dependents (e.g., grandchildren) that is contingent on student status. The notice must go out whenever certification of student status is requested.

IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From Accupac About Your Prescription Drug Coverage and Medicare."

IMPORTANT NOTICE FROM ACCUPAC ABOUT
YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Accupac 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. Accupac has determined that the prescription drug coverage offered by the Accupac Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are “special enrollment periods” that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes “creditable” prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
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. See the Accupac Plan’s summary plan description for a summary of the Plan’s prescription drug coverage. If you don’t have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Accupac Plan due to your employment (or someone else’s employment, such as a spouse or parent), your coverage under the Accupac Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan’s summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Accupac prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan’s eligibility and enrollment rules. You should review the Plan’s summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 215.256.7015 . **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 Accupac changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the “Medicare & You” handbook for their telephone number) for personalized help,

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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

Date:	October 15, 2022
Name of Entity/Sender:	Kimberly Weirman
Contact—Position/Office:	Benefits Coordinator
Address:	1501 Industrial Blvd Mainland, PA 19451
Phone Number:	215.256.7015

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

ACCUPAC
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice is provided to you on behalf of:

Accupac Medical Plan

Accupac Dental Care Plan

Accupac Flexible Benefits Plan

These plans comprise what is called an "Affiliated Covered Entity," and are treated as a single plan for purposes of this notice and the privacy rules that require it. For purposes of this notice, we will refer to these plans as a single "Plan."

The Plan's Duty to Safeguard Your Protected Health Information

Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this notice about its privacy practices that explains how, when, and why the Plan may use or disclose your PHI. Except in

specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this notice, though it reserves the right to change those practices and the terms of this notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by Accupac that describes benefits available to employees and dependents.

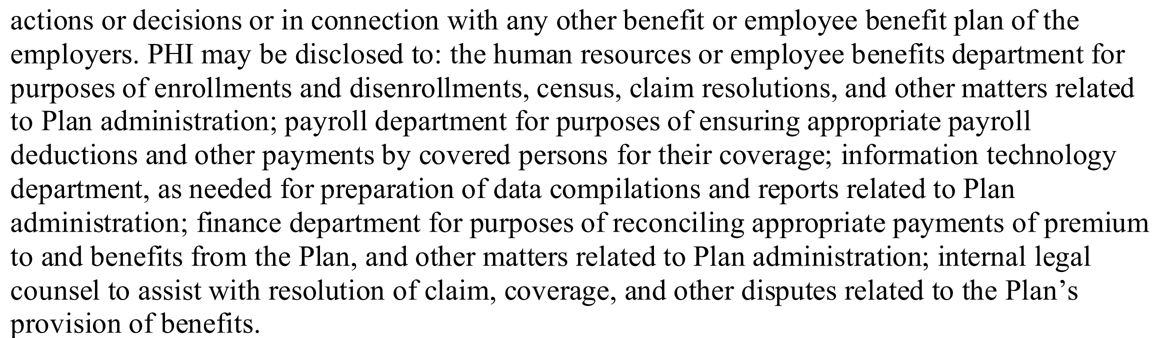
You may also receive one or more other privacy notices from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information
The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

- **Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.**

Treatment: Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists, and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.

  - **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals, and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan and your spouse's plan or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
  - **Health care Operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverages. However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information.
- **Other Uses and Disclosures of Your PHI Not Requiring Authorization.** The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
  - **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as Accupac) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related



actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage, and other disputes related to the Plan's provision of benefits.

  - **To the Plan's Service Providers:** The Plan may disclose PHI to its service providers ("business associates") who perform claim payment and plan management services. The Plan requires a written contract that obligates the business associate to safeguard and limit the use of PHI.
  - **Required by Law**: The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect, or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
  - **For Public Health Activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
  - **For Health Oversight Activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
  - **Relating to Decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
  - **For Research Purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
  - **To Avert Threat to Health or Safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
  - **For Specific Government Functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.
- **Uses and Disclosures Requiring Authorization:** For uses and disclosures beyond treatment, payment, and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. For example, uses and disclosures of psychotherapy notes, uses and disclosures of PHI for marketing purposes, and disclosures that constitute a sale of PHI would require your authorization. Your authorization can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.
- **Uses and Disclosures Requiring You to Have an Opportunity to Object:** The Plan may share PHI with your family, friend, or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Request Restrictions on Uses and Disclosures:** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
- **To Choose How the Plan Contacts You:** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. To request confidential communications, you must make your request in writing to the Privacy Official. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- **To Inspect and Copy Your PHI:** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- **To Request Amendment of Your PHI:** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors you may request in writing that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- **To Find Out What Disclosures Have Been Made:** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain About the Plan's Privacy Practices

If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach
Any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information, or to Submit a Complaint
If you have questions about this notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process*, please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official
The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Kimberly Weirman
Benefits Coordinator
215.256.7015

Organized Health Care Arrangement Designation
The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.
The members of the Organized Health Care Arrangement are:

Accupac Medical Plan
Accupac Dental Care Plan
Accupac Flexible Benefits Plan

Effective Date
The effective date of this notice is: October 15, 2022.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

ACCUPAC EMPLOYEE HEALTH CARE PLAN

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 later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *31 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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 *31 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Kimberly Weirman
Benefits Coordinator
215.256.7015

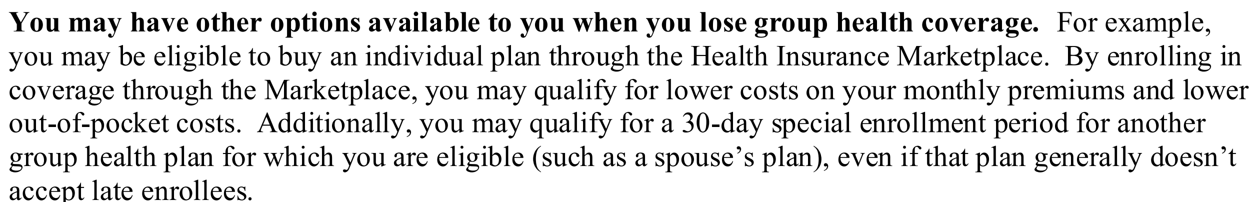
**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

GENERAL COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). 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 Plan 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 qualifying 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.

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 his or her 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."

When is COBRA continuation coverage 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;
- 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 in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and

the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.

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.

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. If you believe you are eligible for this extension, contact the Plan Administrator.

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**.

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[1] 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.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

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**. (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**.

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

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Kimberly Weirman
Benefits Coordinator
1501 Industrial Blvd
Mainland, PA 19451
215.256.7015

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

Accupac Employee Health Care Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 215.256.7015.

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

You do not need prior authorization from Accupac Employee Health Care Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior

authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Accupac Employee Health Care Plan at:

Kimberly Weirman
Benefits Coordinator
215.256.7015

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

Accupac Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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 lymphedemas.

The Accupac Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

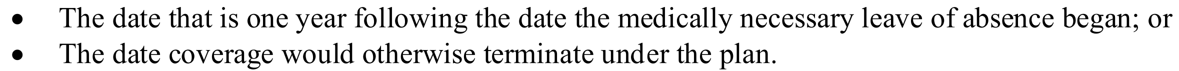
If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Kimberly Weirman
Benefits Coordinator
215.256.7015

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:



- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle’s Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

“Medically necessary leave of absence” means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child’s right to Michelle’s Law’s continued coverage, you should contact Kimberly Weirman , Benefits Coordinator , 215.256.7015.

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, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	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
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – 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	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
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
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	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – 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	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – 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)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – 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	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 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
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	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	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)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

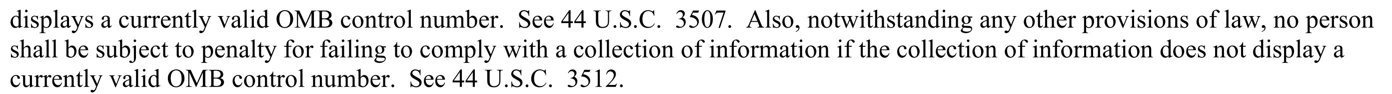
To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it



displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)